Within corporate limits

M

DR. WEISMAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03600

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
LENGTH OF STAY (in this place) 12 wks
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ~~CUMBERLAND~~ Cresaptown
STREET ADDRESS (If rural, give location) ~~RT # 5~~ Knobley View Drive

3. NAME OF DECEASED (Type or Print) (First) FLOYD (Middle) Vyron (Last) ABELL

4. DATE OF DEATH (Month) APRIL (Day) 27 (Year) 1950

5. SEX MALE

6. COLOR OR RACE WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED

8. DATE OF BIRTH FEB 15, 1895

9. AGE last birthday 55 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) KELLY Tire Builder

10b. KIND OF BUSINESS OR INDUSTRY Kelly Springfield Tire Co. DEPT. 52

11. BIRTHPLACE (State or foreign country) W.VA., Slanesville

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME CHARLES ABELL

14. MOTHER'S MAIDEN NAME SALLIE DAVIS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY No. 214-05-9941

17. INFORMANT AND ADDRESS Memorial Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

757.1 Immediate cause (a) Uremia — Interval Between Onset and Death: 6 mos

Antecedent cause(s)

92a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Congenital Polycystic Kidneys — For Life

(c) Aortic valve Calcification — Uncertain

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Bronchopneumonia, Secondary — 4 months

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURRED While at Work ☐ Not While At work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 1946, to April 27, 1950, that I last saw the deceased alive on April 26, 1950, and that death occurred at 7:47 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Saville A. Weisman MD 122 Bedford St Cumberland MD 4/27/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial — DATE April 29, 1950 — NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park — LOCATION (City, town, or county) Cumberland, (State) Md

DATE REC'D BY LOCAL REG. April 28, 1950 — REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR John J. Hofer, ADDRESS Cumberland, Md.

496 2V

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

RECEIVED
MAY 2 1950
BUREAU P. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

03601

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place): 22 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Lonaconing
STREET ADDRESS (If rural, give location): 14 Front St.

3. NAME OF DECEASED (Type or Print): (First) William (Middle) (Last) Anderson

4. DATE OF DEATH: (Month) April (Day) 4 (Year) 1950

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widower

8. DATE OF BIRTH: Feb 7-1863

9. AGE last birthday: 87 yrs.
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Miner

10b. KIND OF BUSINESS OR INDUSTRY: Coal Mine

11. BIRTHPLACE (State or foreign country): Scotland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Andrew Anderson

14. MOTHER'S MAIDEN NAME: Mary Marshall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No

(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Memorial Hospital record

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Acute cardiac failure due to coronary — at once

Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) sclerosis, also had cardiac hypertrophy (moderate) ?

(c) anasarca, & cerebral hemorrhage, internal due to a ruptured arterio sclerotic vessel.

420.1
95c

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy* ☒, *Inspection* ☒, *Inquiry* ☒ *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

SIGNATURE (Degree or title) **ADDRESS** **DATE SIGNED**

H.V. Deming M.D. H.V. Deming M.D. Cumberland Md. April 5-1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF: April 8 1950

NAME OF CEMETERY OR CREMATORY: Oak Hill Cemetery

LOCATION (City, town, or county) (State): Lonaconing, Md.

DATE REC'D BY LOCAL REG.: April 8, 1950

REGISTRAR'S SIGNATURE: Walter L. Kantz, M.D.

24. FUNERAL DIRECTOR: W. Eichhorn Lonaconing, Md.

ADDRESS

45442

RECEIVED
APR 11 1950
BUREAU V. S.

Within corporate limits

DR. VAN ORMER

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03602

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND — LENGTH OF STAY (in this place) 5	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, MD.
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL	STREET ADDRESS (If rural, give location) 123 GRAND AVENUE

3. NAME OF DECEASED (Type or Print) (First) EARL (Middle) F. (Last) AVERS				4. DATE OF DEATH (Month) APRIL (Day) 29 (Year) 1950	
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH APRIL 26 1895	9. AGE last birthday 55 yrs.	If under 1 year Months Days; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRESIDENT KENNEWEG CO.		10b. KIND OF BUSINESS OR INDUSTRY WHOLESALE	11. BIRTHPLACE (State or foreign country) WEST VA.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME JOHN W. AVERS			14. MOTHER'S MAIDEN NAME HILGARTNER, MARY		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	(If year, give war or dates of service) W.W.I	16. SOCIAL SECURITY NO. 214-05-5813	17. INFORMANT AND ADDRESS MEMORIAL HOSPITAL		

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Hypernephroma left kidney with	8 months
180x Antecedent cause(s)	generalized metastasis.	
52a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION none	19b. MAJOR FINDINGS OF OPERATION -	20. AUTOPSY? Yes ☐ No ☑
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1 apr. 59, 19....., to 29 apr., 1956, that I last saw the deceased alive on 28 apr., 1950, and that death occurred at 5.05 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
W. Alfred Van Ormer		Cumberland, Md.	29 apr. 50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	5/1/50	Hillcrest Burial Park	Cumberland Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
May 1, 1950	Winter R. Frantz M.D.	John J. Hafer	Cumberland, Md.

15661

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

tennessee Co. - wholesale grocers

Dr. Murray

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 03603 6

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE PENNA COUNTY SOMERSET
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CRESAPTOWN — LENGTH OF STAY (in this place) 3 mos	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN — (Rural)
HOSPITAL OR INSTITUTION OR STREET ADDRESS POTOMAC-PARK. -	STREET ADDRESS (If rural give location) SALISBURY-PA-RD#1

3. NAME OF DECEASED (Type or Print)	(First) MARY	(Middle) —	(Last) BAER	4. DATE OF DEATH	(Month) APRIL (Day) 6 (Year) 1950
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Feb 14-1869	9. AGE last birthday 81 yrs.	If under 1 year Months / Days; If under 24 hrs. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE	11. BIRTHPLACE (State or foreign country) SOMERSET-Co-PA	12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME JACOB-MILLER		14. MOTHER'S MAIDEN NAME CATHRINE-STEINLY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	16. SOCIAL SECURITY No. NONE	17. INFORMANT Mrs Emma Lancaster			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Exhaustion & Heart Failure	2 months
153x Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Carcinoma Sigmoid	1 year
46e	(c) Caecostomy done	Dec 31/49

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION Dec 31/49	19b. MAJOR FINDINGS OF OPERATION Mass in Sigmoid causing Obstruction	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec, 1949, to April 6, 1950, that I last saw the deceased alive on April 6, 1950, and that death occurred at 1130a m., from the causes and on the date stated above.

SIGNATURE F. Alan G. Murray (Degree or title) MD ADDRESS Cumberland Md DATE SIGNED April 7/50

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL	DATE THEREOF Apr 9-1950	NAME OF CEMETERY OR ~~CREMATORY~~ Greenville Cemetery	LOCATION (City, town, or county) Salisbury Pa RD#1 (State) PA.
DATE REC'D BY LOCAL REG. April 7, 1950	REGISTRAR'S SIGNATURE [signature]	24. FUNERAL DIRECTOR Stanley McThomas	ADDRESS Salisbury Pa

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 12 1950
BUREAU

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03604 4
Reg. Dist. No.

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH: COUNTY Allegany — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 928 Gay St.,

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland,
STREET ADDRESS (If rural, give location) 928 Gay St.,

3. NAME OF DECEASED (Type or Print): (First) LEWIS (Middle) LEONARD (Last) BARLEY
4. DATE OF DEATH (Month) April (Day) 7, (Year) 1950

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: Oct. 19, 1889
9. AGE last birthday: 60 yrs. | If under 1 year: Months. Days. | If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Blacksmith helper
10b. KIND OF BUSINESS OR INDUSTRY: B. & O. Railway
11. BIRTHPLACE (State or foreign country): Winchester, Va.
12. CITIZEN OF WHAT COUNTRY: U. S.

13. FATHER'S NAME: Lewis D. Barley
14. MOTHER'S MAIDEN NAME: Florence A. Bell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W. W. I
16. SOCIAL SECURITY NO.: 705-07-9614
17. INFORMANT AND ADDRESS: Mrs. Helen Barley 928 Gay St. Cumb.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Bronchial asthma — 5 years

241x

Antecedent cause(s)

112

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) ____ (c) ____

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Emphysema — 3 years

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 15, 1949, to Apr. 7, 1950, that I last saw the deceased alive on Apr. 6, 1950, and that death occurred at 5:20 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Ralph W. Ballis M.D. 62 Greene St. Cumberland, Md 4-10-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE: Apr. 11, 1950
NAME OF CEMETERY OR CREMATORY: Hillcrest Cem.
LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: April 10, 1950
REGISTRAR'S SIGNATURE: Walter K. Bantz, M.D.
24. FUNERAL DIRECTOR: Charles L. George
ADDRESS: Cumberland, Md.

VS. A15

35847

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APR 18 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03605

Dr Paul R. Wilson

Reg. Dist. No. 6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport | LENGTH OF STAY (in this place) 72 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 417 Walnut Street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport
STREET ADDRESS (If rural, give location) 417 Walnut Street

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
EMMA	AMELIA	BATIE	April 16, 1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	Whiten	Single	July 11, 1877	72 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic	Own home	Westernport, Maryland	USA

13. FATHER'S NAME: Louis Batie

14. MOTHER'S MAIDEN NAME: Emma Funk

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No	None	Mrs. Bessie Dunk

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
450.0 Immediate cause	(a) Starvation and Malnutrition	2 Weeks
97 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Senility with mention of Senile Dementia	2 Years
	(c) Arterio-sclerosis	4 Years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
None				

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Apr 9, 1950, to Apr 16, 1950, that I last saw the deceased alive on Apr 15, 1950, and that death occurred at 12:10 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Paul R. Wilson	M.D.	Piedmont, W. Va.	4-19-50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	4/19/50	Philos Cemetery	Westernport, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Apr. 19/50	G Baynhaker M.D.	E S Boal,	Westernport, Maryland

RECEIVED
APR 21 1950
BUREAU V. S.

Within corporate limits

Reed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03606

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 3 days.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md
COUNTY: Allegany.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Flintstone
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) Jessie (Middle) Agnes (Last) Bennett

4. DATE OF DEATH: (Month) Apr (Day) 19 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: May 25 1875

9. AGE last birthday: 74 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Flintstone Md.

12. CITIZEN OF WHAT COUNTRY? U-S.

13. FATHER'S NAME: Edbin

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No

16. SOCIAL SECURITY No.: None

17. INFORMANT AND ADDRESS: George S. Bennett 828 Shawnee Ave Cty

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

450 0 **Immediate cause** (a) Myocardial Failure — Interval Between Onset and Death: 1 hour

97 **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arteri-Sclerosis — Unknown

(c) Asthma Bronchial Chr. — Unknown

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY: (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr. 16, 19 50 to Apr 17, 19 50; that I last saw the deceased alive on Apr 17, 19 50, and that death occurred at 6:00 m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Jas E Rees MD — ADDRESS: 40 Y Baker St Cumberland Md — DATE SIGNED: 4/21/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: Apr 22, 1950 — NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery — LOCATION (City, town, or county) (State): Cumberland Md.

DATE REC'D BY LOCAL REG.: April 21, 1950 — REGISTRAR'S SIGNATURE: Wm. K. Frantz, M.D.

24. FUNERAL DIRECTOR: John J Hafer — ADDRESS: Cumberland Md

RECEIVED
APR 25 1950
BUREAU V. R.

Within corporate limits

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03667

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS 505 Linden Street	STREET ADDRESS (If rural, give location) 505 Linden Street

3. NAME OF DECEASED (Type or Print)	(First) OSCAR	(Middle) FRITTHIOF	(Last) BERG	4. DATE OF DEATH (Month) April (Day) 18, (Year) 1950
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH April 26, 1869	9. AGE last birthday 80 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lathe Operator	10b. KIND OF BUSINESS OR INDUSTRY Rubber Tire Co	11. BIRTHPLACE (State or foreign country) Motola, Sweden	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)	16. SOCIAL SECURITY No. 220-10-0125	17. INFORMANT AND ADDRESS Wade Berg, Cumberland, Maryland		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

157x Immediate cause (a) Uremia — Unknown

Antecedent cause(s)

46g Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Nephritis Chronic Glomerular — Unknown

(c) Carcinoma Head Pancreas — Unknown

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 28, 1947, to April 18, 1950, that I last saw the deceased alive on Apr 18, 1950, and that death occurred at 8:45 m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Lewis T Rees Md.		164 Decatur St Cumberland Md	4/20/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 4/21/1950	NAME OF CEMETERY OR CREMATORY Hill Crest Burial Park	LOCATION (City, town, or county) Cumberland, Md. (State)
DATE REC'D BY LOCAL REG. April 21, 1950	REGISTRAR'S SIGNATURE Wintes R. Frantz, M.D.	24. FUNERAL DIRECTOR William H. Kight	ADDRESS Cumberland, Md.

4962

RECEIVED
APR 25 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03608

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 2 mths 9 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: R. Route #1 Crystal Park
STREET ADDRESS (If rural, give location): Mar Cumberland, Rural

3. NAME OF DECEASED (Type or Print): (First) HAZEL CORA (Middle) "LANCASTER" (Last) BITTNER

4. DATE OF DEATH: (Month) April (Day) 5 (Year) 19 50

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Sept 25-1894

9. AGE last birthday: 55 yrs. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Garrett County, Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Burman Lancaster

14. MOTHER'S MAIDEN NAME: Carrie Robison "Lancaster

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Robert G. Bittner, Rt. 1, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Coronary Embolism	2 hours
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Pulmonary Embolism	3 days
	(c) Empyema Appendicitis	14 days

550.0 121

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Operation March 22

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
March 22	Acute Empyema Appendicitis	Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from March 22 1950, to April 5, 1950, that I last saw the deceased alive on April 5, 1950, and that death occurred at 3.50 p.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
F. Alan G. Munro	M.D.	Cumberland, Md.	April 8-50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	April 9, 1950	Greenville Cemetery	Somerset Co.	Pa.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
April 8, 1950	Walter R. Hantz, M.D.	John J. Hoffer	Cumberland, Md.

VS. A17

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APR 11 1950
U.S. NAVAL

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03609

CERTIFICATE OF DEATH

Reg. Dist. No. 10

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt. Savage; LENGTH OF STAY (In this place) Life; HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt. Savage; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Fannie (Middle) Lee (Last) Blank

4. DATE OF DEATH: (Month) April (Day) 22 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: 1865 Apr 9

9. AGE last birthday: 85 yrs. If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Mt. Savage, Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Wilhelm

14. MOTHER'S MAIDEN NAME: America Reese

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Walter Blank

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cebral Hemorrhage — Interval Between Onset and Death: 2 Days

331X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 830 (b) Vascular Hypertension — Several Years

(c) Arteio Sclerosis. — Several Years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 17, 1950, to April 22, 1950, that I last saw the deceased alive on April 22, 1950, and that death occurred at 8:40 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): William E. Mosley M. D. ADDRESS: Mt Savage, Md. DATE SIGNED: April 24. 1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial DATE THEREOF: 4/25/1950 NAME OF CEMETERY OR CREMATORY: St. Georg Episcopal LOCATION (City, town, or county) (State): Mt. Savage, Md.

DATE REC'D BY LOCAL REG. April 25/50 REGISTRAR'S SIGNATURE: Vernon M Bennett

24. FUNERAL DIRECTOR: Harvey H. Leigler ADDRESS: Hyndman, Pa

VS. A15

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APR 27 1950
BUREAU V. S.

Within corporate limits

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03610

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) Life	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS 209 Independence St.	STREET ADDRESS (If rural, give location) 209 Independence St.

3. NAME OF DECEASED (Type or Print)	(First) Matilda	(Middle) Marie	(Last) Blaul	4. DATE OF DEATH	(Month) April (Day) 2, (Year) 1950
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH Jan. 3, 1904	9. AGE last birthday 46 yrs.	If under 1 year Months. Days; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stenographer	10b. KIND OF BUSINESS OR INDUSTRY Rayon (Celanese)	11. BIRTHPLACE (State or foreign country) Cumberland, Md.	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John T. Meders	14. MOTHER'S MAIDEN NAME Eva Buchs				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)	16. SOCIAL SECURITY No. 214 07 1745	17. INFORMANT AND ADDRESS W. Donald Blaul, Cumberland, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Carcinomatosis	2 yrs.
Antecedent cause(s)	(b) Adenocarcinomata - Breast, right	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Cachexia	

170X

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II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 2/20/1948	19b. MAJOR FINDINGS OF OPERATION Adenocarcinoma - Breast. with metastases	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from October, 1949, to April, 1950, that I last saw the deceased alive on April 2, 1950, and that death occurred at 10.15 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
James P. Hallinan M.D.		300 Decatur St. Cumberland, Md.	4/3/1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE April 4, 1950	NAME OF CEMETERY OR CREMATORY St. Peters & Paul Cem.	LOCATION (City, town, or county) (State) Cumberland, Md.
DATE REC'D BY LOCAL REG: April 3, 1950	REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.	24. FUNERAL DIRECTOR William H. Kight, Cumberland, Md.	ADDRESS

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APR 11 1950
BUREAU V. S.

03611

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport
LENGTH OF STAY (in this place) 15 minutes
HOSPITAL OR INSTITUTION OR STREET ADDRESS Reeves Clinic

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rawlings
STREET ADDRESS (If rural, give location) - - - - - - - - - -

3. NAME OF DECEASED (Type or Print) (First) LINDA (Middle) LOU (Last) BOBO
4. DATE OF DEATH (Month) April (Day) 4 (Year) 50 19

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH Jan 29, 1949
9. AGE last birthday 1 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) - - - -
10b. KIND OF BUSINESS OR INDUSTRY - - - - -
11. BIRTHPLACE (State or foreign country) Rawlings Maryland
12. CITIZEN OF WHAT COUNTRY? - - W.

13. FATHER'S NAME James M. Bobo
14. MOTHER'S MAIDEN NAME Ethel Gordon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) -- ---
16. SOCIAL SECURITY NO. None
17. INFORMANT Mrs. Ethel Bobo

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

480x Immediate cause (a) Bronchio Pneumonia — 1 day
Influenza — 3 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)
33a (c) Rickets — 6 mo.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 1, 1950, to April 4, 1950, that I last saw the deceased alive on 4/4 1950, and that death occurred at 4:00 m., from the causes and on the date stated above.

SIGNATURE J. Norman Reeves (Degree or title) M. D. ADDRESS Westernport, Md. DATE SIGNED 4/4/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF April 6, 1950
NAME OF CEMETERY OR CREMATORY Biertown Cemetery
LOCATION (City, town, or county) (State) ~~Westernport~~ Rawlings, Md

DATE REC'D BY LOCAL REG. Apr. 6/50
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR E S Boal ADDRESS Westernport, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 10 1950
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03612

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A17

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 20yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Oldtown, Md.
STREET ADDRESS (If rural, give location): Oldtown, Md.

3. NAME OF DECEASED (Type or Print): (First) Lillian (Middle) Bertha (Last) Boley

4. DATE OF DEATH: (Month) 4/27/50 (Day) (Year) 19

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: I/I5/I878

9. AGE last birthday: 72 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Floodwood, Ohio

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Reinzi Coates

14. MOTHER'S MAIDEN NAME: Lucy Mitchell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Puis Hayes Boley Oldtown, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a): Cerebral Hemorrhage — Interval between onset and death: 3 days

443 x Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b): Hypertension + C.V.D. — Interval between onset and death: Not known

(c): —

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: —

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): —

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: —

(CITY OR TOWN) Cumberland (COUNTY) Alleg (STATE) Md

TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?: —

22. I hereby certify that I attended the deceased from 4/15/47, 19..., to 4/27/50, 19..., that I last saw the deceased alive on 4/27/50, 19..., and that death occurred at 5 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title): W Williams MD — ADDRESS: Cumberland — DATE SIGNED: 4/29/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 5/I/50 — NAME OF CEMETERY OR CREMATORY: Oldtown Cemetery — LOCATION (City, town, or county) (State): Oldtown, Md.

DATE REC'D BY LOCAL REG.: April 29, 1950 — REGISTRAR'S SIGNATURE: Winter R. Frantz M.D.

24. FUNERAL DIRECTOR — ADDRESS: James F. Scarpelli Cumberland, Md.

Dr R Williams

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03613

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 902 Lafayette Ave.,

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland,
STREET ADDRESS (If rural, give location): 902 Lafayette Ave.,

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
MARGARET	MATILDA	BREIGHNER	April	11,	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months.	Days	If under 24 hrs.: Hours	Min.
Female	White	Widowed	Oct. 12, 1873	76 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY: Housewife
11. BIRTHPLACE (State or foreign country): Westminster, Md.
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: John Shattle
14. MOTHER'S MAIDEN NAME: Savilla Baker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT AND ADDRESS: Leo P. Breighner 101 Wempe Drive Cumb. Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cerebral Hemorrhage	48 hr.
Antecedent cause(s)		
331x 83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension	6 yrs.
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from April 9, 1950, to April 11, 1950, that I last saw the deceased alive on April 11, 1950, and that death occurred at 3:15 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Leo a Dyer, MD		247 Va Ave	4-12-50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	April 14/50	St. Patricks	Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
April 13, 1950	Winter R. Frantz, M.D.	H. Wayne George	Cumberland, Md.

RECEIVED
APR 18 1950
BUREAU V. S. ...

Within corporate limits
Dr. Rogers

03614

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland,
STREET ADDRESS (If rural, give location) 10 Columbia St.,

3. NAME OF DECEASED (Type or Print) (First) MARGARET (Middle) EVA (Last) BROOKS

4. DATE OF DEATH (Month) April (Day) 21, (Year) 1950

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH Nov. 4, 1867
9. AGE last birthday 82 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Domestic
11. BIRTHPLACE (State or foreign country) Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Augustus M. Barrett
14. MOTHER'S MAIDEN NAME Elizabeth Connelly

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT AND ADDRESS Mrs. Arthur Twigg 10 Columbia St.,

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Peritonitis

541.1 Antecedent cause(s)

117b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Ruptured Duodenal Ulcer

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 4/17/50
19b. MAJOR FINDINGS OF OPERATION Ruptured duodenal ulcer
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/16, 1950, to 4/21, 1950, that I last saw the deceased alive on 4/21, 1950, and that death occurred at 8:20 A m., from the causes and on the date stated above.

SIGNATURE John K Rogers M.D. (Degree or title) ADDRESS Cumberland Md DATE SIGNED 4/22/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 4/24/50
NAME OF CEMETERY OR CREMATORY Hillcrest Cem.
LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REG. April 23, 1950
REGISTRAR'S SIGNATURE Wrister R. Wantz, M.D.
24. FUNERAL DIRECTOR Charles L. George Cumberland, Md. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 25 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03615

Reg. Dist. No. 10

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS-A13

1. PLACE OF DEATH
COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mt Savage
LENGTH OF STAY (in this place): 85 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Railroad St.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mt Savage
STREET ADDRESS (If rural, give location): Railroad St.

3. NAME OF DECEASED (Type or Print): (First) Wm (Middle) Henry (Last) Carter

4. DATE OF DEATH: (Month) Apr (Day) 5 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Dec 11, 1864

9. AGE last birthday: 85 yrs. — If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Blacksmith

10b. KIND OF BUSINESS OR INDUSTRY: C & P Railroad

11. BIRTHPLACE (State or foreign country): Mt Savage, Md.

12. CITIZEN OF WHAT COUNTRY?: U.S

13. FATHER'S NAME: Abner Carter

14. MOTHER'S MAIDEN NAME: Miriam Jenkins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: Mrs Bertha Martin - Mt Savage Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a): Coronary Thrombosis — Interval Between Onset and Death: Moments

Antecedent cause(s) (b): Vascular Hypertension — Interval Between Onset and Death: Several Years

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1947 to April 3, 1950, that I last saw the deceased alive on April 3, 1950, and that death occurred at 12:30 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title): William E. Morley — ADDRESS: Mt Savage Md. — DATE SIGNED: April 5-1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: Apr 8 1950 — NAME OF CEMETERY OR CREMATORY: Mt Savage Methodist — LOCATION (City, town, or county): Mt. Savage (State): Md

DATE REC'D BY LOCAL REG.: 4-8-50 — REGISTRAR'S SIGNATURE: Veronica McDermott

24. FUNERAL DIRECTOR: John J. Hafer — ADDRESS: Mt Savage Md.

302-47

BUREAU V. D.
MAR 11 1960

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03616

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place) 52 yrs.; HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural, give location) 307 Crawford Street

3. NAME OF DECEASED (Type or Print): (First) John; (Middle); (Last) Clancey, Sr.

4. DATE OF DEATH: (Month) April; (Day) 15; (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: July 24 1871

9. AGE last birthday: 78 yrs.; If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Roller

10b. KIND OF BUSINESS OR INDUSTRY: Plate Mill

11. BIRTHPLACE (State or foreign country): Ireland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Pearce Clancey

14. MOTHER'S MAIDEN NAME: Bridget Sullivan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No; (If year, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT: John Clancey, Jr.

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
450.0 Immediate cause	(a) Acute Bronchitis	24 hours
Antecedent cause(s)		
106a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis, generalized	Unknown
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION; 19b. MAJOR FINDINGS OF OPERATION; 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify); PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY; (CITY OR TOWN); (COUNTY); (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.; INJURY OCCURRED While at Work ☐ Not While At work ☐; HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-5-50 to 4-15-50, that I last saw the deceased alive on 4-15-50, and that death occurred at 5 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

J. W. Johnson Jr. M.D. 16 Greene St Cumberland Md 4-17-50

23. BURIAL, CREMATION, REMOVAL (Specify); DATE; NAME OF CEMETERY OR CREMATORY; LOCATION (City, town, or county) (State)

Burial April 18, 1950 St. Mary's Cem Cumberland Md

DATE REC'D BY LOCAL REG.; REGISTRAR'S SIGNATURE; 24. FUNERAL DIRECTOR; ADDRESS

April 17, 1950 Walter L. Wantz, M.D. James F. Scarpelli, Cumberland, Md.

39436

RECEIVED
APR 25 1950
BUREAU V.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03617

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 28 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 242 Bond Street

3. NAME OF DECEASED (Type or Print) (First) Ernest (Middle) Hammersley (Last) Cook
4. DATE OF DEATH (Month) April (Day) 23 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH May 24, 1888
9. AGE last birthday 61 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician
10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.
11. BIRTHPLACE (State or foreign country) Philadelphia Pa
12. CITIZEN OF WHAT COUNTRY? U.S

13. FATHER'S NAME Wm B. Cook
14. MOTHER'S MAIDEN NAME Mary Blair

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO. 086-07-6026
17. INFORMANT AND ADDRESS Mrs Ernest Cook 242 Bond St Cumb Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

541.1 Immediate cause (a) Peritonitis

Antecedent cause(s)

117b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Ruptured duodenal ulcer

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death

19a. DATE OF OPERATION 4/17/50
19b. MAJOR FINDINGS OF OPERATION Ruptured duodenal ulcer
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/15, 1950, to 4/23, 1950, that I last saw the deceased alive on 4/23, 1950, and that death occurred at 6:20 A.m., from the causes and on the date stated above.

SIGNATURE John K. Rozum MD (Degree or title) ADDRESS Cumberland Maryland DATE SIGNED 4/25/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Apr 26, 1950
NAME OF CEMETERY OR CREMATORY St Peter + Pauls Cath. Cem
LOCATION (City, town, or county) Cumberland (State) Md

DATE REC'D BY LOCAL REG. April 25, 1950
REGISTRAR'S SIGNATURE Winter R. Wantz, M.D.
24. FUNERAL DIRECTOR John J Hafer, Cumberland Md ADDRESS

3/4/6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 2 1950
BUREAU OF S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03618

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland | LENGTH OF STAY (in this place) 17 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 103 Mary Street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 103 Mary Street

3. NAME OF DECEASED (Type or Print): (First) ANNA (Middle) ELIZABETH (Last) CREEK

4. DATE OF DEATH: (Month) April (Day) 2, (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Nov. 7, 1865

9. AGE last birthday: 84 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Piney Plains, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Alford Creek

14. MOTHER'S MAIDEN NAME: Rebecca Roberts

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No | (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Mrs. Leo Leasure, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
1144 Immediate cause	(a) Cardiac failure	6 mo.
Antecedent cause(s)		
102 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension	10 yr.
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 1, 1949, to Apr. 2, 1950, that I last saw the deceased alive on Apr. 2, 1950 and that death occurred at 1 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED
John A Dyer, M.D. | 247½ Ave. | 4-3-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE: April 5, 1950 | NAME OF CEMETERY OR CREMATORY: Piney Plains Cemetery | LOCATION (City, town, or county) (State): Piney Plains, Md.

DATE REC'D BY LOCAL REG.: April 5, 1950 | REGISTRAR'S SIGNATURE: Walter K. Frantz, M.D. | 24. FUNERAL DIRECTOR: William H. Kight | ADDRESS: Cumberland, Md.

RECEIVED
APR 11 1950
BUREAU U. S.

Within corporate limits

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

03619

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 10 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE W.Va. COUNTY Hampshire
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Springfield
STREET ADDRESS (If rural, give location) ✓

3. NAME OF DECEASED (Type or Print) (First) John (Middle) Wasley (Last) Crock

4. DATE OF DEATH (Month) April (Day) 3 (Year) 1950

5. SEX male

6. COLOR OR RACE white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married

8. DATE OF BIRTH March 11-1883

9. AGE last birthday 67 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer Tie plant

10b. KIND OF BUSINESS OR INDUSTRY Wood Preserving

11. BIRTHPLACE (State or foreign country) Springfield W.Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John W.Crock Sr.

14. MOTHER'S MAIDEN NAME Susan Kerns

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 705-05-2990

17. INFORMANT John W.Crock

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pulmonary embolism due to a	about 10 min.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) recent operation(cystotomy)	
	(c) Carcinoma of the prostate	?

177x
51b

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE H.V.Deming M.D. (Degree or title) H.V. Deming M.D. ADDRESS Cumberland Md. DATE SIGNED April 3-1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE THEREOF 6 Apr '50 NAME OF CEMETERY OR ~~CREMATORY~~ Indian Mound Cem LOCATION (City, town, or county) Romney (State) W.Va

DATE REC'D BY LOCAL REG. April 3, 1950 REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR H.C. Ruckman ADDRESS Romney. W.Va.

000VV

RECEIVED
MAR 11 1950
BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

03620

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md.; COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mexico Farm Rural; LENGTH OF STAY (in this place) 50 yrs	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural) Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS Cumberland Md. R.F.D.#4	STREET ADDRESS (If rural, give location) Mexico Farm R.F.D #4

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
James	Alexander	Cunningham	April 18 1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
male	white	widower	Nov.14-1878	71 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer (self employed	Farm owner	N.Branch Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
David C. Cunningham	Ann G. Summerfield

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no	None	Mrs.Wilbur Sions Purgittsville,W. Va.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
835.1 **Immediate cause**	(a) Pulmonary hemorrhage due to	about 5 minutes
1750 **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) punctured lung from fractured ribs, right side.	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☒ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY farm	(CITY OR TOWN) near Cumberland	(COUNTY) Allegany	(STATE) Md.
TIME OF INJURY (Month) (Day) (Year) (Hour) April 18/50 about 10. a.m.	INJURY OCCURRED While at work ☒ Not while at work ☐	HOW DID INJURY OCCUR? Plowing with a tractor, He's tractor rolled over in 15 ft. ditch, soft dirt gave away.		

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H.V.Deming M.D. H.V. Deming M.D.		Cumberland,Md.	April 19-1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	April 20,1950	Olivet Cem.	Lahmansville, W. Va.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
April 19,1950	Winter R. Trautz, M.D.	H. Wayne George	Cumberland, Md.

VS. A15A

RECEIVED
APR 25 1950
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

03621

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (In this place): 2 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Ellerslie
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) Cloyd (Middle) F. (Last) Devore

4. DATE OF DEATH: (Month) April (Day) 26 (Year) 1950

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: Oct. 8-1928

9. AGE last birthday: 21 (22) yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Serviceman - Service Dept.

10b. KIND OF BUSINESS OR INDUSTRY: Celanese Corp.

11. BIRTHPLACE (State or foreign country): Ellerslie Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John E. Devore

14. MOTHER'S MAIDEN NAME: Sarah J. Tyson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 216-22-7261

17. INFORMANT: Hospital record.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
816.5 Immediate cause	(a) Epidural hemorrhage due to a	2 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) fractured skull	
170C	(c) Cerebral edema (marked)	2 days

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☒ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: in the Narrows — (CITY OR TOWN): route 40 near Cumberland — (COUNTY): Allegany — (STATE): Md.

TIME OF INJURY (Month) (Day) (Year) (Hour): April 24 1950 2:50 P.m.

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR? Head on crash of two automobiles.

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title): H. V. Deming M.D. — ADDRESS: H. V. Deming M.D. Cumberland Md. — DATE SIGNED: April 26-1950

23. BURIAL, CREMATION REMOVAL (Specify): BURIAL — DATE THEREOF: April 29 1950 — NAME OF CEMETERY OR CREMATORY: Porter — LOCATION (City, town, or county): HYNDMAN — (State): PA

DATE REC'D BY LOCAL REG.: April 27 1950 — REGISTRAR'S SIGNATURE: Walter L. Lantz, M.D.

24. FUNERAL DIRECTOR: Harvey H. Zeigler — ADDRESS: Hyndman, Pa

3310

RECEIVED
MAY 2 1950
BUREAU F. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

036229

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place) Lifetime
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg (Finzel)
STREET ADDRESS (If rural, give location) R.L. No 2 Box 185

3. NAME OF DECEASED (Type or Print) (First) John (Middle) Francis (Last) Lorcas

4. DATE OF DEATH (Month) 4 (Day) 1 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 3-6-1884
9. AGE last birthday 66 yrs. If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY Owner
11. BIRTHPLACE (State or foreign country) Mt. Savage, Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Casper Lorcas
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY No. None
17. INFORMANT AND ADDRESS Mrs John F. Lorcas R.L. No 2 Frostburg, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
523.0	Immediate cause	(a) Heart failure	4 days
	Antecedent cause(s)		
97	Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Silicosis	10 years
		(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1948, to 3-31, 1950, that I last saw the deceased alive on 3-31, 1950, and that death occurred at 4:20 a.m., from the causes and on the date stated above.

SIGNATURE Adolf Wolferman (Degree or title) M.D. ADDRESS Frostburg, Md. DATE SIGNED 4-1-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 4-4-1950
NAME OF CEMETERY OR CREMATORY St. Annie's Cem
LOCATION (City, town, or county) Carlton (State) Md.

DATE REC'D BY LOCAL REG. 4-3-50
REGISTRAR'S SIGNATURE Mrs Nancy H. Roe
24. FUNERAL DIRECTOR Jacob Hafer ADDRESS Frostburg, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 10 1950
BUREAU V. S.

Evidence for addition in #13 shown on: Within corporate limits

FILM No. G 125 APR 18 1950

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03623

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 427 Va. Ave.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Wilbert	Bert	Elbin	Apr.	6,	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Married	Aug. 17, 1885	64 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Tender Repairman	Railroad	Mt. Hope, Penna.	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
George Elbin	Karrie Ann Kerenhappuch

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No	705-12-3265	Mrs. Goldie Ridenour Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause (a)	Cardiac failure	1 hrs.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)	Uremia	2 wks
(c)	chronic nephritis (4/17/50 akc)	

592 131 L

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Jan, 19 50, to Apr. 6, 19 50, that I last saw the deceased alive on Apr 6, 19 50, and that death occurred at 4:45 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Edward Dyer, M.D. 247 Va Ave 4-7-50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	4-9-1950	Mt. Hope	Mt. Hope, Penna.

DATE REC'D BY LOCAL REG:	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
April 8, 1950	Wrates L. Hartz, M.D.	Charles L. George	Cumberland, Md.

4967

RECEIVED
APR 11 1960
BUREAU V. S.

Within corporate limits 247 V Dyer

Evidence for addition in #18 shown on:

03624

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

FILM No. G 125 MAY 4 1950

Reg. Dist. No. 4

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place): 1 day
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 104 Park Street

3. NAME OF DECEASED (Type or Print): (First) Sarah (Middle) May (Last) Evans

4. DATE OF DEATH: (Month) April (Day) 11 (Year) 1950

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: Aug. 13, 1903
9. AGE last birthday: 46 yrs. — If under 1 year: Months, Days — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Hyndman, Penna.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Evans
14. MOTHER'S MAIDEN NAME: Alice Kennedy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT AND ADDRESS: Pearl Bartgis, Barrelville, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cardiac failure — 3 days

592 Antecedent cause(s)

131b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Uremia — 1 yr.

(c) chronic nephritis (5/3/1950) akc)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr. 9, 1950, to Apr. 11, 1950, that I last saw the deceased alive on Apr. 11, 1950, and that death occurred at 3:20 A.M., from the causes and on the date stated above.

SIGNATURE: John A. Dyer (Degree or title) M.D. — ADDRESS: 247 Vadue, 1 — DATE SIGNED: 4-12-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: April 13, 1950 — NAME OF CEMETERY OR CREMATORY: Hyndman Cem. — LOCATION (City, town, or county) (State): Hyndman, Pa.

DATE REC'D BY LOCAL REG.: April 12, 1950 — REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D. — 24. FUNERAL DIRECTOR: Harvey H. Zeigler — ADDRESS: Hyndman, Pa.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

RECEIVED
APR 18 1950
BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

03625

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Cumberland; HOSPITAL OR INSTITUTION OR STREET ADDRESS: R.F.D.#1 Valley Road; MARYLAND; LENGTH OF STAY (In this place): 6 months

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md.; COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Cumberland; STREET ADDRESS (If rural, give location): R.F.D #1 Valley Road.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Patrick	H.	Fahey	April	29	19 50

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	white	married	Oct.20-1889	60 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired clerk	Construction Savage River Dam	Elk Garden W.Va.	U.S.A.

13. FATHER'S NAME: Michael P.Fahey

14. MOTHER'S MAIDEN NAME: Mary Grady

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: >

17. INFORMANT: Mrs. P.H.Fahey (wife)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
420,1 Immediate cause	(a) Coronary occlusion	at once
94a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	?
	(c) Arteriosclerosis	?

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: noturol causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
H.V.Deming M.D. H V Deming M.D.	Cumberland Md.	May 1-1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	May 2, 1950	St. Patricks Cemetery	Cumberland, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
May 1, 1950	Walter L. Beatty, M.D.	Harold Fedlock, Piedmont, W. Va.	

26679

RECEIVED
MAY 5 1950
BUREAU OF

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03626

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sylvan Retreat

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt. Savage
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	Anna	Katherine	Foster		April	10	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	White	Widowed	12/11/1859	90 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Maryland	USA

13. FATHER'S NAME: William Gerlach

14. MOTHER'S MAIDEN NAME: Mary Ossman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No	None	Richard T. Hammill, 131 W. Main, Frstbg

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause	(a) Myocardial failure	10 days
Antecedent cause(s)		
94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary Sclerosis	15 yrs
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from Dec, 1946, to Apr. 10, 1950, that I last saw the deceased alive on Apr. 8, 1950, and that death occurred at 9:15 a m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Arthur F. Jones	M.D.	110 S. Centre St.	Apr. 11, 1950

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	April 12, 1950	Lutheran Cemetery	Frostburg, Md.

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
April 11, 1950	Walter K. Mantz, M.D.	Jacob Hafer	Frostburg, Md.

VS-A13

RECEIVED
APR 18 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03627

CERTIFICATE OF DEATH

Reg. Dist. No. 10

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mt. Savage
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mt. Savage
STREET ADDRESS (If rural, give location): Columbia Avenue

3. NAME OF DECEASED (Type or Print): (First) MARY (Middle) ETTA (Last) FRANKENBERRY

4. DATE OF DEATH: (Month) April (Day) 4, (Year) 1950

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: 3-22-1881

9. AGE last birthday: 69 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Robert Lashley

14. MOTHER'S MAIDEN NAME: Dorcas Robinette

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY No.: none

17. INFORMANT AND ADDRESS: Mrs. Jesse Gordon, Mt. Savage, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.2 **Immediate cause** (a) Myocarditis — Interval Between Onset and Death: 2½ years

93e **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Extreme Anaemia — 6 mo.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from January, 1948, to April 4, 1950, that I last saw the deceased alive on April 4, 1950, and that death occurred at 11:30 A.m., from the causes and on the date stated above.

SIGNATURE: William E. Mosley (Degree or title) — ADDRESS: Mt Savage Md — DATE SIGNED: April 5-1950

23. BURIAL, CREMATION REMOVAL (Specify): Burail — DATE: 4-7-50 — NAME OF CEMETERY OR CREMATORY: Methodist Cemetery — LOCATION (City, town, or county) (State): Mt. Savage, Md.

DATE REC'D BY LOCAL REG.: 4-7-1950 — REGISTRAR'S SIGNATURE: Veronica McDermott

24. FUNERAL DIRECTOR — ADDRESS: J. R. Durst, Frostburg, Md.

VS. A15

RECEIVED
APR 11 1950
BUREAU V. S.

DR. VAN ORMER

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03628

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND | LENGTH OF STAY (in this place) 1 DAY
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND — COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN WESTERNPORT
STREET ADDRESS (If rural, give location) 38 MAIN STREET

3. NAME OF DECEASED (Type or Print): (First) JOHN (Middle) Q. Adams (Last) GASTER
4. DATE OF DEATH: (Month) APRIL (Day) 12, (Year) 1950

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED
8. DATE OF BIRTH: FEB. 7, 1871
9. AGE last birthday: 79 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Dairy Farm
11. BIRTHPLACE (State or foreign country): PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY: USA.

13. FATHER'S NAME: JOHN Q. GASTER
14. MOTHER'S MAIDEN NAME: Sarah Jane NEWCOMER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | (If year, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL -CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cardiac Failure	1 month
420.0 Antecedent cause(s)	arterio-sclerotic Heart Disease	
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Bronchial Pneumonia, secondary to above.	1 week
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Generalized arteriosclerosis

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov., 1950, to Dec. 12th, 1950, that I last saw the deceased alive on Dec. 12th, 1950, and that death occurred at 2:48 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED
W. Alfred Vance, Cumberland, md. | Dec. 12 1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE: 4-15-50 | NAME OF CEMETERY OR CREMATORY: North Glade Cem. | LOCATION (City, town, or county) (State): Swanton Md.

DATE REC'D BY LOCAL REG.: April 12, 1950 | REGISTRAR'S SIGNATURE: Winter R. Wantz, M.D.

24. FUNERAL DIRECTOR: C. S. Boal | ADDRESS: Westernport Md

0000

RECEIVED
APR 18 1950
BUREAU V. A.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03629

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Sylvan Retreat

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg, Md.; STREET ADDRESS (If rural, give location) 130 Centre St.

3. NAME OF DECEASED (Type or Print): (First) Irwin; (Middle) Engel; (Last) Gilbert

4. DATE OF DEATH: (Month) 4; (Day) 24; (Year) 1950

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M

8. DATE OF BIRTH: 8-28-1874

9. AGE last birthday: 75 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED - Own Business photographer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Philadelphia, Pa.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Howard Alonzo Gilbert

14. MOTHER'S MAIDEN NAME: Georganna Rolinda Hellings

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No

16. SOCIAL SECURITY No.: None

17. INFORMANT AND ADDRESS: Mrs. Gilbert (wife)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Coronary Occlusion	20 min
Antecedent cause(s) 420.1 940 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Renal arteriosclerosis	4 yrs
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 7, 1950, to Apr. 24, 1950, that I last saw the deceased alive on Apr. 24, 1950, and that death occurred at 1:05 p m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Arthur F. Jones M.D. 110 S. Centre St. Apr. 24, 1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE: 4 - 27-50

NAME OF CEMETERY OR CREMATORY: Frostburg Mem. Park

LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG.: April 26, 1950

REGISTRAR'S SIGNATURE: Walter L. Lantz, M.D.

24. FUNERAL DIRECTOR ADDRESS: Joseph R. Durst, Frostburg, Md.

V6689

RECEIVED
MAY 2 1950
BUREAU N. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

03630

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 55 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: in ambulance to the Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 114 N. Mechanic St.

3. NAME OF DECEASED (Type or Print): (First) Georgia (Middle) A. (Last) Gilmore

4. DATE OF DEATH: (Month) April (Day) 7 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Feb. 14-1895

9. AGE last birthday: 55 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife & waitress

10b. KIND OF BUSINESS OR INDUSTRY: Restaurant

11. BIRTHPLACE (State or foreign country): Cumberland Md

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Henry J. Taylor

14. MOTHER'S MAIDEN NAME: Mary Jane ---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213-22-3148

17. INFORMANT: John Gilmore, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 **Immediate cause** (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: about 1 Hr.

94a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Coronary sclerosis — ?

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H. V. Deming M.D. H. V. Deming M.D. Cumberland Md. April 7-1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: 4/10/1950 | NAME OF CEMETERY OR CREMATORY: Woodlawn Cemetery | LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: April 10, 1950 | REGISTRAR'S SIGNATURE: Walter L. Fantz, M.D.

24. FUNERAL DIRECTOR ADDRESS: William H. Kight Cumberland, Md.

78071

RECEIVED
APR 18 1950
BUREAU V. S.

ITEM 15: funeral director's letter filmed G126 5-17-50 (CB #645) L

Within corporate limits

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03631

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Pa — COUNTY: Somerset
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place): 24 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Somerset
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital	STREET ADDRESS (If rural, give location): 597 E. Main St.

3. NAME OF DECEASED (Type or Print)	(First) A	(Middle) Miller	(Last) Glessner	4. DATE OF DEATH	(Month) April	(Day) 24	(Year) 1950
5. SEX: M	6. COLOR OR RACE: W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: Jan. 10, 1891	9. AGE last birthday: 59 yrs.	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Coal Operator	10b. KIND OF BUSINESS OR INDUSTRY: Self employed	11. BIRTHPLACE (State or foreign country): Pa.	12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME: Frank P. Glessner	14. MOTHER'S MAIDEN NAME: Sarah Miller						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No YES	(If year, give war or dates of service): WW#1	16. SOCIAL SECURITY No.: None	17. INFORMANT AND ADDRESS: Memorial Hospital				

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

443x

Immediate cause (a) Chronic Hypertensive

Antecedent cause(s) (b) Cardiovascular Disease — Unknown

93d

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-31-, 1950, to 4-24, 1950, that I last saw the deceased alive on 4-24, 1950, and that death occurred at 1 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Wm. F. Williams	M.D.	Cumberland	4-24-50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Apr 27, 1950	Ridge Reformed Cemetery	Somerset Co.	Pa.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
April 24, 1950	Winter R. Frantz, M.D.	John J. Hafer	Cumberland, Md.

ALSO: HAUGER FUNERAL HOME Somerset Pa.

454 V2

RECEIVED
MAY 2 1950
BUREAU N. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03632

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH: COUNTY Allegany; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place) 59 yrs.; HOSPITAL OR INSTITUTION OR STREET ADDRESS 404 Tilghman

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural, give location) 404 Tilghman St.

3. NAME OF DECEASED (Type or Print): (First) Elizabeth (Middle) May (Last) Hammond

4. DATE OF DEATH: (Month) Apr (Day) 22 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Nov 16, 1878

9. AGE last birthday: 71 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Town Creek, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Henry Shryock

14. MOTHER'S MAIDEN NAME: Alice Huff

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No

16. SOCIAL SECURITY No.: none

17. INFORMANT AND ADDRESS: Mrs Helen Reifer Cumberland Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Enlargement of Liver (Ca or Cirrhosis) — Interval between onset and death: 1 yr.

156.1 Antecedent cause(s)

107 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Ascites — 3 mon.

(c) Bronchopneumonia — 3 days

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan., 1950, to Apr. 22, 1950, that I last saw the deceased alive on Apr. 22, 1950 and that death occurred at 11:30 A.m., from the causes and on the date stated above.

SIGNATURE W. Royce Hodges (Degree or title) ADDRESS 122 So. Centre St. DATE SIGNED 4/24/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: Apr 25, 1950 — NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery — LOCATION (City, town, or county) (State): Cumberland Md.

DATE REC'D BY LOCAL REG.: April 24, 1950 — REGISTRAR'S SIGNATURE: Wirter K. Lantz, M.D. — 24. FUNERAL DIRECTOR: John J. Hafer — ADDRESS: Cumberland Md.

RECEIVED
MAY 2 1950
BUREAU OF S.

NAME: DR. VAN ORMER'S LETTER FILMED G126 6-12-50 LL:: JAMES EDGAR HARMISON.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03633

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 45 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 37 Humbird St.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 37 Humbird St.

3. NAME OF DECEASED (Type or Print): (First) Edgar (Middle) JAMES J. EDGAR (Last) Harmison

4. DATE OF DEATH: (Month) Apr (Day) 10 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Retired

8. DATE OF BIRTH: March 10 1881

9. AGE last birthday: 69 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Car Repairman

10b. KIND OF BUSINESS OR INDUSTRY: Railway

11. BIRTHPLACE (State or foreign country): Keyser W. Va

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Floyd Harmison

14. MOTHER'S MAIDEN NAME: Louise Landon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. — (If year, give war or dates of service)

16. SOCIAL SECURITY No.: 705-10-3627

17. INFORMANT AND ADDRESS: George Harmison, Cumberland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a): Cardiac Failure

420.1 Antecedent cause(s) — Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b): Hypertensive & Coronary Heart Disease — ?

94a (c):

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death: Generalized arteriosclerosis

19a. DATE OF OPERATION | **19b. MAJOR FINDINGS OF OPERATION** | **20. AUTOPSY?** Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 30 Dec., 1948, to 10 Apr., 1950, that I last saw the deceased alive on 4 Apr., 1950, and that death occurred at 1 A m., from the causes and on the date stated above.

SIGNATURE: W. Alfred Vir Orme — (Degree or title) — ADDRESS: Cumberland, Md — DATE SIGNED: 12 Apr. 1950

23. BURIAL, CREMATION OR REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	April 13, 50	Hillcrest Mem	Cumberland	Md

DATE REC'D BY LOCAL REG:	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
April 13, 1950	Winter R. Frantz, M.D.	Louis Stein Inc	Cumberland

33447

RECEIVED
APR 18 1950
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03634

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland | LENGTH OF STAY (in this place) 25 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 229 Carroll St.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
William	Henry	Harvey	4	5	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
M	W	M	Oct. 6, 1892	57 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrician Helper
10b. KIND OF BUSINESS OR INDUSTRY: Celanese Corp.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edwin Harvey
14. MOTHER'S MAIDEN NAME: Clara Unknown (born in England)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | (If year, give war or dates of service)
16. SOCIAL SECURITY NO. 217-10-4960
17. INFORMANT AND ADDRESS: Mrs. William H. Harvey, 229 Carroll St

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Malaria (Therapeutic inoculation)	3 wks
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	CNS Syphilis	8 yrs

0261
30C

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 20, 1950, to Apr. 5, 1950, that I last saw the deceased alive on Apr. 4, 1950, and that death occurred at 8:50 p m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Arthur F. Jones M.D.		110 S. Centre St.	Apr. 6, 1950

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Apr. 8, 1950	Rose Hill Cemetery	Cumberland,	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
April 5, 1950	Winter R. Mantz, M.D.	John J. Hofer, Cumberland,	Md.

3149

RECEIVED
APR 11 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03635

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place) life
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cresaptown
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Barbara (Middle) Jane (Last) Helmstetter

4. DATE OF DEATH: (Month) (Day) (Year) April 3, 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: Jan. 14, 1950

9. AGE last birthday: yrs. If under 1 year: Months 2 | Days | If under 24 hrs.: Hours | Min. 19

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: Infant

11. BIRTHPLACE (State or foreign country): Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Ferman Helmstetter

14. MOTHER'S MAIDEN NAME: Mae Clinedinst

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Ferman Helmstetter, Cresaptown, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) respiratory infection	24 hrs
754.4 Antecedent cause(s)	(b) congenital malformation	since
1572 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) of the heart	birth

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/4, 19 50, to 4/3, 19 50, that I last saw the deceased alive on 4/3, 19 50, and that death occurred at 11:03 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Edgar Briggs M.D. ADDRESS 55 Greene St. DATE SIGNED 4/5/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE 4/5/1950 | NAME OF CEMETERY OR CREMATORY St Ambrose Cemetery | LOCATION (City, town, or county) (State) Cresaptown, Md.

DATE REC'D BY LOCAL REG. April 5, 1950 | REGISTRAR'S SIGNATURE Winter R. Hantz, M.D.

24. FUNERAL DIRECTOR ADDRESS: William H. Kight, Cumberland, Md.

2-A-1-14-0-32-6-40-5

RECEIVED
APR 11 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

03636

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mt. Savage
LENGTH OF STAY (in this place): 50 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: P.O.Box 71

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mt Savage
STREET ADDRESS (If rural, give location): P.O.Box 71

3. NAME OF DECEASED (Type or Print): (First) William (Middle) T. (Last) Holsinger

4. DATE OF DEATH: (Month) April (Day) 22 (Year) 19 50

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widower

8. DATE OF BIRTH: Jan.18-1867

9. AGE last birthday: 83 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired, R.R.Engineer

10b. KIND OF BUSINESS OR INDUSTRY: C&P R.Ry.

11. BIRTHPLACE (State or foreign country): near ,Frostburg Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: David Holsinger

14. MOTHER'S MAIDEN NAME: Annie E. Winebriner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 712-14-1561

17. INFORMANT: John Sanson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Coronary occlusion	at once
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	?
	(c) Arteriosclerosis	?

420.1
94a

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) ..m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

H.V.Deming M.D. H. V. Deming M.D. Cumberland Md. April 23-1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: 4-26-1950 | NAME OF CEMETERY OR CREMATORY: Methodist | LOCATION (City, town, or county) (State): Mt.Savage, Md.

DATE REC'D BY LOCAL REG.: April 25 - 50 | REGISTRAR'S SIGNATURE: Vernon McDermitt

24. FUNERAL DIRECTOR | ADDRESS: Joseph R. Durst, Frostburg, Md.

32247

RECEIVED
APR 27 1950
BUREAU V. R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03637

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A13

1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Route 1, Frostburg — LENGTH OF STAY (in this place):	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Route 1, Frostburg
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Klondike	STREET ADDRESS (If rural, give location): Klondike

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
JOSEPH	MARTIN	HOUSE	April	4,	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months. / Days	If under 24 hrs.: Hours / Min.
Female	white	married	2-16-1868	82 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
retired miner	Coal mines	West Virginia	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Samuel House	Elizabeth O'Farrell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
no	none	Mrs. Rose Snyder, Akron, Ohio

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
443	Immediate cause	(a) Chr Myocarditis	3 mo
	Antecedent cause(s)		several
93d	Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension	years
		(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Feb 28 1950, to Apr 4, 1950, that I last saw the deceased alive on Apr 3, 1950, and that death occurred at 7:15 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Wm C Lane MD	Frostburg Md	4-5-50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	4-6-50	Allegany Cemetery	Frostburg, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
4-6-50	Mrs. Nancy N. Roe	J. R. Durst,	Frostburg, Md.

45402

RECEIVED
APR 10 1950
BUREAU V. S.

Within corporate limits: DR. W. F. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03638

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE PENN COUNTY BEDFORD
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND — LENGTH OF STAY (in this place) 14 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Near FLINTSTONE, Maryland
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL	STREET ADDRESS (If rural, give location) RT # 1 ✓

3. NAME OF DECEASED (Type or Print)	(First) ELMA	(Middle) PEARL	(Last) IMES	4. DATE OF DEATH	(Month) April	(Day) 11	(Year) 1950
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE	8. DATE OF BIRTH FEB. 13, 1925	9. AGE last birthday 25 yrs.	If under 1 year Months	Days	If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Twisting operator	10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.	11. BIRTHPLACE (State or foreign country) PENN.	12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME KELLEY S. IMES	14. MOTHER'S MAIDEN NAME OLEDA DELL KEEFER						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)	16. SOCIAL SECURITY NO. 216-22-702	17. INFORMANT AND ADDRESS Kelly S. Imes, Rt. 1, Flintstone, Md.					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

442x Immediate cause (a) Cardio vascular

Antecedent cause(s)

133b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Renal disease (uremia).

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3.28., 1950, to 4-11-, 1950, that I last saw the deceased alive on 4.11., 1950, and that death occurred at 12:45 P.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
W. F. Williams	M.D.	Cumberland	4.12.50

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE April 14, 1950	NAME OF CEMETERY OR CREMATORY Chaneysville Methodist	LOCATION (City, town, or county) Chaneysville, (State) Pa
DATE REC'D BY LOCAL REG. April 14, 1950	REGISTRAR'S SIGNATURE Winter K. Frantz, M.D.	24. FUNERAL DIRECTOR John J. Hofer, Cumberland, Md.	ADDRESS

49616

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 18 1950
BUREAU V. S.

Within corporate limits

03640

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland,
HOSPITAL OR INSTITUTION OR STREET ADDRESS 628 Yale St.,	STREET ADDRESS (If rural, give location) 628 Yale St.,

3. NAME OF DECEASED (Type or Print)	(First) CORA	(Middle) M.	(Last) JUDY	4. DATE OF DEATH	(Month) April	(Day) 22,	(Year) 1950	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widowed	8. DATE OF BIRTH Aug. 20, 1881	9. AGE last birthday 68 yrs.	If under 1 year: Months.	Days	If under 24 hrs.: Hours	Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Domestic	11. BIRTHPLACE (State or foreign country) Cumberland, Md.	12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME Theodore Rice		14. MOTHER'S MAIDEN NAME Ida Paxton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)	16. SOCIAL SECURITY NO. None	17. INFORMANT AND ADDRESS Mrs. Clarence Stewart 628 Yale St.,	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Occlusion	½ hr.
420.1 Antecedent cause(s)		
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension & myocardial degeneration	(months)
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Dec, 1949, to April 22, 1950, that I last saw the deceased alive on April 22, 1950, and that death occurred at 7:00 P. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
George M Brown	M.D.	Cumberland, Md	4/22/50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	4/25/50	Hillcrest Cem.	Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
April 25, 1950	Wentz K. Frantz, M.D.	Charles L. George	Cumberland, Md.

VS-A15

52086

RECEIVED
MAY 2 1950
BUREAU V. S.

DR. W.F.WILLIAMS

Eichhorn

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03641

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: ALLEGANY — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: MARYLAND — COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND — LENGTH OF STAY (In this place): 29 DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: PEKIN
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL	STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
MARTHA		KIFER	APRIL	19	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
FEMALE	WHITE	WIDOW	JULY 5, 1877	72 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
Housewife	Own Home	MARYLAND	USA.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
MARK BAKER	FAZENBAKER, JULIA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No	None	MEMORIAL HOSPITAL CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Thrombosis	Sudden
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cardiovascular renal disease.	
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Diabetes Mellitus	

420.1 61 260

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 3.21., 1950 to 4.19., 1950, that I last saw the deceased alive on 4.19., 1950, and that death occurred at 4:20 P.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Wm. F. Williams	M.D.	Cumberland	4.20.50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	April 22, 1950	Laurel Hill Cemetery	Moscow, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
April 20, 1950	Vernes K. Kantz, M.D.	M. Eichhorn,	Lonaconing, "

VS-A15

RECEIVED
APR 25 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03642

CERTIFICATE OF DEATH

Reg. Dist. No. 6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport
LENGTH OF STAY (in this place) 80 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 109 Poplar St

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport
STREET ADDRESS (If rural, give location) 109 Poplar St

3. NAME OF DECEASED (Type or Print): (First) WILHELMINA (Middle) (Last) KIGHT

4. DATE OF DEATH: (Month) April (Day) 29 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED W

8. DATE OF BIRTH: July 25, 1863

9. AGE last birthday: 86 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Frostburg, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Schell

14. MOTHER'S MAIDEN NAME: Frederika Schmidt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No — (If yes, give war or dates of service) — — —

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Ernest Schell

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 Immediate cause (a) Coronary Thrombosis — Interval Between Onset and Death: 1 hr.

94a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) arteriosclerosis — 10 yrs.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) — m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from July, 1949, to Apr. 29, 1950, that I last saw the deceased alive on Apr. 29, 1950, and that death occurred at 8 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

P E Berry M.D Piedmont, W Va. May 2 1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: May 2, 1950 — NAME OF CEMETERY OR CREMATORY: Philos Cemetery — LOCATION (City, town, or county) (State): Westernport, Maryland

DATE REC'D BY LOCAL REG. May 2 50 — REGISTRAR'S SIGNATURE J Baynhaber M.D.

24. FUNERAL DIRECTOR — ADDRESS: E. S. Boal, Westernport, Maryland

VS. A15

RECEIVED
MAY 6 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Dr. Wolferman

03643

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 257 E. Main St.,

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
STREET ADDRESS (If rural, give location): 257 E. Main St.

3. NAME OF DECEASED (Type or Print): (First) Annie (Middle) Statia (Last) Kinney

4. DATE OF DEATH: (Month) April (Day) 7, (Year) 1950

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed

8. DATE OF BIRTH: 11-21-1870

9. AGE last birthday: 79 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (State or foreign country): Mt. Savage, Md.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Thomas Dunn

14. MOTHER'S MAIDEN NAME: Mary Homer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT AND ADDRESS: Howard Kinney, Washington D. C.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
170x **Immediate cause**	(a) metastatic carcinoma in both lungs	6 months
Antecedent cause(s)		
50 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Carcinoma of the breast	2 years
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

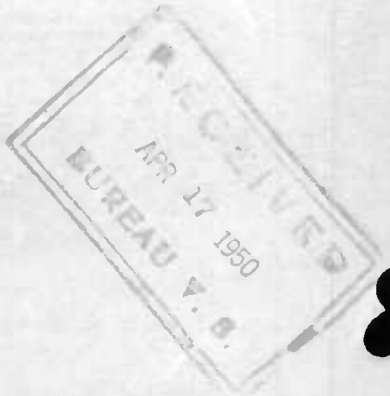
HOW DID INJURY OCCUR?:

22. I hereby certify that I attended the deceased from 3-1, 1950, to 4-7, 1950, that I last saw the deceased alive on 4-2, 1950 and that death occurred at 12:45 p.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
A. Wolferman	M.D.	Frostburg, Md	4-8-50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burail	4-10-1950	Allegany Cemetery	Frostburg, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
4-10-50	Mrs Howard N. Roe	J. R. Durst, Frostburg, Md.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APR 17 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

03644

Reg. Dist. No. 1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: rural Cumberland
LENGTH OF STAY (in this place): 1 week
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Green Ridge Station

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md.
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 209 Emily St.

3. NAME OF DECEASED (Type or Print): (First) Clarence (Middle) John (Last) Koegel

4. DATE OF DEATH: (Month) April (Day) 20 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: May 1-1886

9. AGE last birthday: 63 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinest

10b. KIND OF BUSINESS OR INDUSTRY: Mc Kaig's foundry

11. BIRTHPLACE (State or foreign country): Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Koegel

14. MOTHER'S MAIDEN NAME: Katherine Zink

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 214-05-6711

17. INFORMANT: Eleanor Crabtree (daughter)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Acute cardiac failure due to	at once
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic myocarditis	about 6 years
	(c)	

422.2
932

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION / **19b. MAJOR FINDINGS OF OPERATION**

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURRED While at work ☐ Not while at work ☐ HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H.V.Deming M.D. H.V. Deming M.D. Cumberland Md. April 20-1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: April 22, 1950 | NAME OF CEMETERY OR CREMATORY: St. Lukes Cem | LOCATION (City, town, or county) (State): Cumberland, Md

DATE REC'D BY LOCAL REG.: April 24, 1950 | REGISTRAR'S SIGNATURE: Sue C. Linevan M.D. 4/24/50 | 24. FUNERAL DIRECTOR ADDRESS: James F. Scarpelli, Cumberland, Md

32641

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APR 26 1950
BUREAU V. S.

03645

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE West Va COUNTY Mineral
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland Md. LENGTH OF STAY (in this place) 8 days.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN R.F.D. #1 Keyser W. Va.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital	STREET ADDRESS (If rural, give location) 4

3. NAME OF DECEASED (Type or Print)	(First) Sharon	(Middle) Fay	(Last) Lease	4. DATE OF DEATH (Month) 4/9/50 (Day) (Year) 19
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) S	8. DATE OF BIRTH 4/1/50	9. AGE last birthday yrs. If under 1 year Months. Days 8 If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland Cumberland	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Baker B Lease		14. MOTHER'S MAIDEN NAME Dorothy Simpson		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)	16. SOCIAL SECURITY NO. None	17. INFORMANT AND ADDRESS Memorial Hosp.		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

761.5 Immediate cause (a) Prematurity

Antecedent cause(s)

160c Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) 7½ mo —

(c) Premature Separation Placenta

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on 8 Apr, 1950, and that death occurred at.....m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Fuller B. Whitworth	M.D.	Cumberland Md	9 Apr 50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	April 11, 1950	Mt Zion Cemetery	Near Keyser, West Virginia

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
April 9, 1950	Winter L. Frantz, M.D.	N Howard Rogers	Keyser, W Va.

2-0-4-01-0-35-R-32-2

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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APR 18 1950
BUREAU V. S.

Within corporate limits

DR. J. A. JONES

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03646

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: ALLEGANY	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: MARYLAND; COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND; LENGTH OF STAY (in this place): 19 DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Was CUMBERLAND Rural
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL	STREET ADDRESS (If rural, give location): RT. #6.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
THOMAS	EDISON	LEPLEY	Apr.	13,	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
MALE	WHITE	SINGLE	MAR. 11, 1917	33 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Glass Picker	Glass factory	MARYLAND	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
LODA B. LEPLEY	PLEASANT ANDERSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No	220-10-7158	MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
355x Immediate cause	(a) Degenerative cerebral cortical disease	20 yrs.
Antecedent cause(s)		
87c Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Feb. 3, 1950, to Apr. 13, 1950, that I last saw the deceased alive on Apr. 12, 1950, and that death occurred at 11:45 am., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Arthur F. Jones	M.D.	110 S. Centre St.	Apr. 14, 1950

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	4/16/50	Mt. Pleasant	near Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
April 15, 1950	Walter K. Dantz, M.D.	H. Wayne George	Cumberland, Md.

49625

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APR 18 1950
BUREAU F. S.

Within corporate limits

M

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03647

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland, LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland,
HOSPITAL OR INSTITUTION OR STREET ADDRESS 61 Greene St.,	STREET ADDRESS (If rural, give location) 61 Greene St.,

3. NAME OF DECEASED (Type or Print)	(First) CARL	(Middle) A.	(Last) LOW, Sr.	4. DATE OF DEATH	(Month) April (Day) 15, (Year) 1950
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH May 12, 1890	9. AGE last birthday 59 yrs.	If under 1 year Months. Days / If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self employed surveyor	10b. KIND OF BUSINESS OR INDUSTRY Civil Engineer	11. BIRTHPLACE (State or foreign country) Towanda, Penna.	12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Charles B. Low		14. MOTHER'S MAIDEN NAME Margaret Wilking			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	(If year, give war or dates of service)	16. SOCIAL SECURITY No. 214-05-4356	17. INFORMANT AND ADDRESS Mrs. Ruth Low, 61 Greene St., Cumb. Md		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary occlusion	1 day
420.1 Antecedent cause(s)		
94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

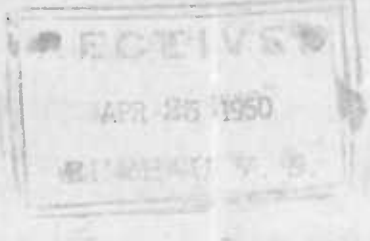
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-12, 1950, to 4-15, 1950, that I last saw the deceased alive on 4-15, 1950, and that death occurred at 9:35a m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Ralph W. Bullin	M.D.	62 Greene St. Cumberland Md	4-17-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 4/18/50	NAME OF CEMETERY OR CREMATORY Hillcrest Cem.	LOCATION (City, town, or county) (State) Cumberland, Md.
DATE REC'D BY LOCAL REG. March 18, 1950	REGISTRAR'S SIGNATURE Wrates R. Frantz. M.D.	24. FUNERAL DIRECTOR H. Wayne George	ADDRESS Cumberland, Md.

V9293


RECEIVED
APR 25 1950

Within corporate limits DR. WEISMAN

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A13

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03648

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND — LENGTH OF STAY (in this place) 1 DAY	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL	STREET ADDRESS (If rural, give location) 118 REYNOLDS STREET

3. NAME OF DECEASED (Type or Print): (First) RUTH (Middle) M (Last) MAFFLEY

4. DATE OF DEATH: (Month) APRIL (Day) 23 (Year) 1950

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED

8. DATE OF BIRTH: JAN. 1, 1899

9. AGE last birthday: 51 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: LEMUEL WILLISON

14. MOTHER'S MAIDEN NAME: MARY BRANT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			Interval Between Onset and Death
451x	Immediate cause	(a) ~~Pneu~~ Hemopericardium & Cardiac tamponade	15 minutes
	Antecedent cause(s)		
96	Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Dissecting aneurysm	36 hours
		(c) Medial necrosis of Aorta	36 hours

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Hypertensive & Arteriosclerotic heart Disease 10 years

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 22, 1950, to April 23, 1950, that I last saw the deceased alive on April 23, 1950, and that death occurred at 9:10 a.m., from the causes and on the date stated above.

SIGNATURE: Saville G. Weisman (Degree or title) MD — ADDRESS: 122 Bedford St Cumberland, Md — DATE SIGNED: 4/26/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: 4-26-1950 — NAME OF CEMETERY OR CREMATORY: HillCrest — LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: April 26, 1950 — REGISTRAR'S SIGNATURE: Winter R. Frantz M.D.

24. FUNERAL DIRECTOR: Charles L. George — ADDRESS: Cumberland, Md.

RECEIVED
MAY 2 1950
BUREAU V.S.

Within corporate limit.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03649

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
MARYLAND
LENGTH OF STAY (In this place): 92 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 511 Greene St.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland.
STREET ADDRESS (If rural, give location): 511 Greene St.

3. NAME OF DECEASED (Type or Print): (First) Laura (Middle) Catherine (Last) Wales

4. DATE OF DEATH: (Month) April (Day) 21 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: June 15 1858

9. AGE last birthday: 91 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: at Home

11. BIRTHPLACE (State or foreign country): Cumberland Md

12. CITIZEN OF WHAT COUNTRY?: U S A

13. FATHER'S NAME: John Carey

14. MOTHER'S MAIDEN NAME: Eliza Able

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Mrs Henry Payne, Cumberland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Myocarditis, Senile	20 Mo +
199.1 Antecedent cause(s)		
552 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Sarcoma, Rt leg (Below Knee)	20 Mo.
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 18, 1948, to Apr 21, 1950 that I last saw the deceased alive on Apr 21, 1950, and that death occurred at 7:00 P m., from the causes and on the date stated above.

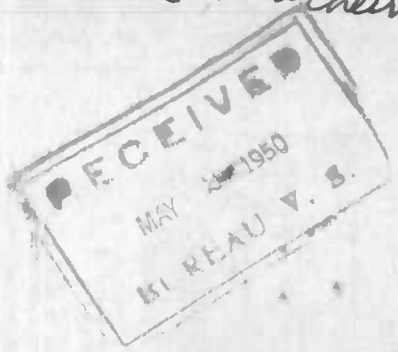
SIGNATURE: L. B. Mackenzie M.D. (Degree or title) ADDRESS: 49 Greene St DATE SIGNED: 4/22/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial DATE: Apr 25, 50 NAME OF CEMETERY OR CREMATORY: Rose Hill Cem. LOCATION (City, town, or county) (State): Cumberland Md.

DATE RECD BY LOCAL REG.: April 25, 1950 REGISTRAR'S SIGNATURE: Walter L. Hanby, M.D.

24. FUNERAL DIRECTOR ADDRESS: Louis Stein Sons. Cumberland.

Dr Mathews



MARYLAND STATE DEPARTMENT OF HEALTH

03650

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural) near Flintstone Md. — LENGTH OF STAY (In this place): 22 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: in Autoomobile, in route to the Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural) P.O. Flintstone
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Arlie (Middle) (Last) Mallow

4. DATE OF DEATH: (Month) April (Day) 10 (Year) 19 50

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: March 25-1899

9. AGE last birthday: 51 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer - Machinist Dye House - Rayon Textile Mfg.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): near Riverton W.Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Wyatt Grant Mallow

14. MOTHER'S MAIDEN NAME: Ida Dolly

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 220-10-4458

17. INFORMANT: Floyd Mallow (son) Flintstone, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 **Immediate cause** (a) Coronary occlusion — Interval Between Onset and Death: about 15 minutes

94a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Coronary sclerosis — ?

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy* ☒, *Inspection* ☒, *Inquiry* ☒ *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

SIGNATURE (Degree or title): H.V.Deming M.D. H. V. Deming M. D. — ADDRESS: Cumberland Md. — DATE SIGNED: April 10-1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: April 12, 1950 — NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park — LOCATION (City, town, or county) (State): Cumberland, Maryland

DATE REC'D BY LOCAL REG.: April 11, 1950 — REGISTRAR'S SIGNATURE: Nina L. Bender.

24. FUNERAL DIRECTOR — ADDRESS: John J. Hafer, Cumberland, Md.

RECEIVED
APR 14 1950
BUREAU OF S.

Within corporate limits

M

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03651

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 107 Polk St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 107 Polk St.

3. NAME OF DECEASED (Type or Print) (First) Harry (Middle) (Last) Margolis

4. DATE OF DEATH (Month) April (Day) 27 (Year) 1950

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH 6-10-1890

9. AGE last birthday 59 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Taylor - Tailor

10b. KIND OF BUSINESS OR INDUSTRY Self

11. BIRTHPLACE (State or foreign country) Latvia

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME Oscar Margolis

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY No. None

17. INFORMANT AND ADDRESS Allegany Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Embolism (Rt) — INTERVAL BETWEEN ONSET AND DEATH: 1 day

420.1 Antecedent cause(s) c̄ Paralysis left side —

61 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Coronary Insufficiency. Acute left ventricular failure — 2 days

(c) Paralysis and Aurium Intoxication — 2 days

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus - bathlegs amputated 5 -

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURRED While at Work ☐ Not While At work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/25, 1950, to 4/27, 1950, that I last saw the deceased alive on 4/27, 1950, and that death occurred at 1:45P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Samuel Jackson MD 50 Pershing St Cumb Md 4/28/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE 4-28-50 NAME OF CEMETERY OR CREMATORY East View Cemetery LOCATION (City, town, or county) Cumberland (State) Md.

DATE REG'D BY LOCAL REG. April 28, 1950 REGISTRAR'S SIGNATURE Winter R. Frantz, MD

24. FUNERAL DIRECTOR Louis Stein, Inc. ADDRESS Cumberland, Maryland

360

RECEIVED
MAY 2 1934
BUREAU V. S.

Within corporate limits DR. DAUGHERTY

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03652

Reg. Dist. No. 4

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH · COUNTY ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND — LENGTH OF STAY (in this place) 12 DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL CUMBERLAND, MD.	STREET ADDRESS (If rural, give location) 113 N. CENTER STREET

3. NAME OF DECEASED (Type or Print)	(First) HOWARD	(Middle)	(Last) MARTIN	4. DATE OF DEATH	(Month) APRIL (Day) 4 (Year) 1950
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH JUNE 15 1875	9. AGE last birthday 74 yrs.	If under 1 year Months. Days; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance agent	10b. KIND OF BUSINESS OR INDUSTRY Insurance	11. BIRTHPLACE (State or foreign country) XXX WEST VIRGINIA	12. CITIZEN OF WHAT COUNTRY? USA.		
13. FATHER'S NAME GEORGE MARTIN		14. MOTHER'S MAIDEN NAME MARY ROBERTS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If year, give war or dates of service)	16. SOCIAL SECURITY NO. None	17. INFORMANT AND ADDRESS MEMORIAL HOSPITAL, CUMBERLAND, MD.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
332X	Immediate cause	(a) Cerebral Thrombosis	3 days
83b	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arterio-Sclerosis (General	+4 years.
		(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr 12, 1950, to Apr 24, 1950, that I last saw the deceased alive on Apr 24, 1950, and that death occurred at 9.25 a.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Leslie E Daugherty	M.D.	7 Wash St Cumberland Md.	4-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 4/6/1950	NAME OF CEMETERY OR CREMATORY Percy Cemetery	LOCATION (City, town, or county) (State) Frostburg, Md.
DATE REC'D BY LOCAL REG. April 5, 1950	REGISTRAR'S SIGNATURE Winter R. Frantz, MD	24. FUNERAL DIRECTOR William H. Kight, Cumberland, Md.	ADDRESS

27480

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Within corporate limits

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03653

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) 11 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ~~Cumberland~~ Westernport, rural
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary	STREET ADDRESS (If rural, give location) Brophytown, Franklin ~~Westernport, Md.~~

3. NAME OF DECEASED (Type or Print)	(First) John	(Middle) B.	(Last) Martin	4. DATE OF DEATH	(Month) 4 (Day) 5 (Year) 1950
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 1/27/65	9. AGE last birthday 85 yrs.	If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meat Cutter - Retired	10b. KIND OF BUSINESS OR INDUSTRY Grocery Store	11. BIRTHPLACE (State or foreign country) Franklin, Md. (Brophytown)	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Joseph Martin		14. MOTHER'S MAIDEN NAME Margaret Grapes			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	(If year, give war or dates of service)	16. SOCIAL SECURITY No. None	17. INFORMANT AND ADDRESS Allegany County Infirmary		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a)	Myocardial failure	2 wks
420.1 Antecedent cause(s)			
94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	Coronary sclerosis	4 yrs
	(c)		

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar. 26, 1950, to Apr 5, 1950, that I last saw the deceased alive on Apr. 4, 1950, and that death occurred at 9:40 a m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Arthur F. Jones M.D.		110 S. Centre St.	Apr. 6, 1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	April 8, 1950	Burlington Cemetery	Burlington, W. Va.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
April 6, 1950	Winter R. Frantz, M.D.	Ellsworth S Boal	Westernport, Md.

45261

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APR 11 1950
BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03654

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS 531 Henderson Ave	STREET ADDRESS (If rural, give location) 531 Henderson Ave

3. NAME OF DECEASED (Type or Print): (First) Barbara (Middle) Elizabeth (Last) Matt

4. DATE OF DEATH: (Month) Apr (Day) 20 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Mar 9, 1873

9. AGE last birthday: 77 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Cumberland Md

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Urban Miller

14. MOTHER'S MAIDEN NAME: Mary Rahrig

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Lawrence Matt, 804 Maplewood Lane

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Bronchogenic Carcinoma	1 year
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c) Pulmonary Tuberculosis	25 years

162x

47c

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-6, 1949, to 4-20, 1950, that I last saw the deceased alive on 4-19, 1950, and that death occurred at 1:30 a.m., from the causes and on the date stated above.

SIGNATURE: Ralph W. Ballin, M.D. (Degree or title) ADDRESS: 62 Greene St. Cumberland Md DATE SIGNED: 4-21-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: Apr 22, 1950 — NAME OF CEMETERY OR CREMATORY: St Peter & Pauls Cath. Cem. — LOCATION (City, town, or county) (State): Cumberland Md

DATE REC'D BY LOCAL REG.: April 21, 1950 — REGISTRAR'S SIGNATURE: Winter R. Wantz, M.D. — 24. FUNERAL DIRECTOR: John J. Hofer — ADDRESS: Cumberland Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
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Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03655

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) MARYLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 109 Bellevue Street

3. NAME OF DECEASED (Type or Print): (First) Fannie (Middle) Rebecca (Last) McCarty

4. DATE OF DEATH: (Month) 4 (Day) 2 (Year) 1950

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M

8. DATE OF BIRTH: Mar. 17-1872

9. AGE last birthday: 78 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Simeon Coleman

14. MOTHER'S MAIDEN NAME: Mary Hager

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: John H. McCarty, 109 Bellevue St, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

492 X Immediate cause (a) Virus Pneumonitis — Interval between onset and death: 1 wk

Antecedent cause(s)

109 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 27, 1949, to Apr. 2, 1950, that I last saw the deceased alive on Mar. 31, 1950, and that death occurred at 9:25 p m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Arthur E. Jones M.D. 110 S. Centre St. Apr. 3, 1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE: Apr. 5, 1950 | NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park | LOCATION (City, town, or county) (State): Cumberland Md

DATE RECD BY LOCAL REG.: April 5, 1950 | REGISTRAR'S SIGNATURE: Walter L. Lantz, M.D.

24. FUNERAL DIRECTOR ADDRESS: John J. Hafer Cumberland, Md.

RECEIVED
APR 11 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03656

CERTIFICATE OF DEATH

Reg. Dist. No. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Anna M. McPartland

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): September 21, 1907

8. AGE: Years	Months	Days	If less than one day
42	5	9	..... hrs. ..... min.

9. Birthplace: Lonaconing, Allegany, Maryland
(Town, county, and state)

10. Usual occupation: School Teacher

11. Industry or business: Public School

FATHER
12. Name: Bernard McPartland
13. Birthplace

MOTHER
14. Maiden name: Elizabeth Brenan
15. Birthplace

16. Informant: Edward McPartland
Address: Lonaconing, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 3, 1950 (month) (day) (year)
Cemetery or crematory: St. Michaels Cemetery
Location: Frostburg, Maryland

18. Funeral director: M. Eichhorn
Address: Lonaconing, Maryland.

19. 5-3 1950 (Date rec'd by registrar) Jeannette M. Boal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4 / 30 1950, at 9:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3 / 12 1949 to 4 / 30 1950 and that I last saw h.e.r. alive on 4 / 30 1950

Immediate cause of death	DURATION
Adenocarcinoma of small intestine & generalized	
Due to Carcinomatosis	1 yr.
Due to	
Other conditions 152x 462 (Include pregnancy within 3 months of death)	

Major findings of operations: operated upon by Dr. Rogers - Cumberland. Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Paul Eugene Dye, M.D.
M. D. or other
Address: Lonaconing Md. Date signed 5/2/50

V3491

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MAY 12 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH Dr Wilson

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 02657

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Barton — LENGTH OF STAY (in this place) 74 yrs	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Barton
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) JOHN (Middle) AARON (Last) METZ			4. DATE OF DEATH (Month) April (Day) 7, (Year) 1950	
5. SEX ~~XXXXX~~ M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH June 24, 1875	9. AGE last birthday 74 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner retired	10b. KIND OF BUSINESS OR INDUSTRY Coal Mine	11. BIRTHPLACE (State or foreign country) Barton, Maryland	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Metz		14. MOTHER'S MAIDEN NAME Ellen Poland		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None	16. SOCIAL SECURITY NO. 214-03-1510	17. INFORMANT Mrs. John Howell		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
241X Immediate cause	(a) Pulmonary Edema	One Day
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic Myocarditis and Myocardial Degeneration Not Specified as Rheumatic	Two Years
93d	(c) Chronic Bronchitis (Asthma)	Five Years

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. La Grippe — Three Weeks

19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify) None	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 17, 1949, to Apr. 7, 1950, that I last saw the deceased alive on Apr. 7, 1950, and that death occurred at 4:10 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Paul R Wilson	M.D.	Piedmont, W. Va.	Apr. 9, 1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF Apr 12, 50	NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery	LOCATION (City, town, or county) (State) Moscow, Maryland
DATE REC'D BY LOCAL REG. Apr. 12/50	REGISTRAR'S SIGNATURE [signature]	24. FUNERAL DIRECTOR E. S. Boal	ADDRESS Westernport, Maryland

454V2

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03658

Reg. Diat. No. 8

1. PLACE OF DEATH: Allegany
County.....
City or town..... Klondike
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 67 years
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town..... Klondike
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3.(a) FULL NAME: Robert Miller

3.(b) Social Security Number: ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Agnes Miller
6.(c) If alive, give age.....years

7. Birth date of deceased (mo., day, yr.): October 6, 1882

8. AGE: Years	Months	Days	If less than one day
67	6	11	.....hrs. .....min.

9. Birthplace: Scotland (Town, county, and state)
10. Usual occupation: Janitor
11. Industry or business: Steele Mill

FATHER
12. Name: Unknown
13. Birthplace: -

MOTHER
14. Maiden name: Unknown
15. Birthplace: -

16. Informant: Leo McNeil
Address: Klondike, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 19, 1950 (month) (day) (year)
Cemetery or crematory: Oak Hill Cemetery
Location: Lonaconing, Md.
18. Funeral director: M. Eichhorn
Address: Lonaconing, Md.

19. 4-19 1950 (Date rec'd by registrar) Jeannette M Boal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 17 1950, at 4:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1950 to April 17 1950
and that I last saw him alive on April 16 1950.

	DURATION
Immediate cause of death: Pulmonary edema	2 days
Due to: Congestive heart decease	6 mo.
Due to: Hypertension, nephritis, arteriosclerosis	10 yrs.
Other conditions	

442x
131a
(Include pregnancy within 3 months of death)
Major findings of operations..... Date of op.....
Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?).....
Means of injury..... Injured at work?

23. SIGNATURE: W E Gattens M.D.
M. D. or other
Address: Frostburg Md. Date signed 4/19/50

74029

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAY 1 1950
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03659

Reg. Dist. No. 9

1. PLACE OF DEATH · COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Eckhart
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Miners Hospital	STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	(First) CATHARINE	(Middle) REGINA	(Last) MYERS	4. DATE OF DEATH	(Month) April (Day) 6, (Year) 1950
5. SEX: female	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed	8. DATE OF BIRTH: 9-16-1878	9. AGE last birthday: 71 yrs.	If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife	10b. KIND OF BUSINESS OR INDUSTRY: home	11. BIRTHPLACE (State or foreign country): Maryland	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME: Edwin Goodwin	14. MOTHER'S MAIDEN NAME: Catherine Murray				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY No.: none	17. INFORMANT AND ADDRESS: Wayne Myers, Eckhart, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

422.2 Immediate cause (a) Chr Myocarditis — 1 year

Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1949, 19....., to Apr 6, 1950, that I last saw the deceased alive on Apr 6, 1950, and that death occurred at 6:15 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
W O McLane MD		Frostburg Md	4-7-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: 4-9-50	NAME OF CEMETERY OR CREMATORY: Eckhart Cemetery	LOCATION (City, town, or county) (State): Eckhart, Md.
DATE REC'D BY LOCAL REG.: 4-9-50	REGISTRAR'S SIGNATURE: Mrs. Nancy N. Roe	24. FUNERAL DIRECTOR: J. R. Durst, Frostburg, Md.	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 17 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03660

Reg. Dist. No. 8

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing; MARYLAND; LENGTH OF STAY (in this place) 62 years; HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Mamie (Middle) Rosette (Last) Nicol

4. DATE OF DEATH: (Month) April (Day) 20 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Feb 26, 1888

9. AGE last birthday: 62 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: John Dawson

14. MOTHER'S MAIDEN NAME: Dane Grove

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Thomas Nicol

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Status epilepticus — due

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) to epilepsy attack —

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ..., 1948, to 4/20, 1950, that I last saw the deceased alive on 4/20, 1950, and that death occurred at 1 10 P m., from the causes and on the date stated above.

SIGNATURE Paul Eugene Dyes (Degree or title) M.D ADDRESS Lonaconing DATE SIGNED 4/22/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial; DATE THEREOF: April 23, 1950; NAME OF CEMETERY OR CREMATORY: DYES CEMETERY; LOCATION (City, town, or county) (State): LONACONING? MD

DATE REC'D BY LOCAL REG. 4-23-50; REGISTRAR'S SIGNATURE Jeannette M Boal

24. FUNERAL DIRECTOR: M. EICHHORN; ADDRESS: LONACONING? MD

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 1 1950
BUREAU P. S.

Within corporate limit

03661

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS. A15

1. PLACE OF DEATH· COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED· STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) life	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sylvan Retreat	STREET ADDRESS (If rural, give location) 617 N. Centre St.

3. NAME OF DECEASED (Type or Print)	(First) Lottie	(Middle) Shaffer	(Last) Myers	4. DATE OF DEATH	(Month) 4	(Day) 3	(Year) 1950
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) W	8. DATE OF BIRTH ~~Unknown~~ About 1867	9. AGE last birthday 82 yrs.	If under 1 year Months.	Days	If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Maryland, Cumberland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Adam Shaffer		14. MOTHER'S MAIDEN NAME Caroline Fauber	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)	16. SOCIAL SECURITY NO. None	17. INFORMANT AND ADDRESS Mrs. Carrie C. Gabler, Atlantic City, N.J.	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Myocardial Failure	1 hr.
450.1 Antecedent cause(s)		
94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	12 yrs.
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec, 1946, to Apr. 3, 1950, that I last saw the deceased alive on Mar. 31, 1950, and that death occurred at 7:30 a m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Arthur F. Jones	M.D.	110 S. Centre St.	Apr. 3, 1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE April 5-1950	NAME OF CEMETERY OR CREMATORY St. Lukes Cem.	LOCATION (City, town, or county) Cumberland	(State) Md.
DATE REC'D BY LOCAL REG. April 3, 1950	REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.	24. FUNERAL DIRECTOR Louis Stein Inc.	ADDRESS 117 Fredrick St.	

RECEIVED
APR 11 1950
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

03662

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (In this place) 4 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md.; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural, give location) 16 Locust St.

3. NAME OF DECEASED (Type or Print): (First) John (Middle) M. (Last) Nine

4. DATE OF DEATH: (Month) (Day) (Year) April 28 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Feb. 22-1901

9. AGE last birthday: 49 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Yard Foreman

10b. KIND OF BUSINESS OR INDUSTRY: B&O.R.Ry.

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Gilbert Nine

14. MOTHER'S MAIDEN NAME: Minnie Elsey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 214-07-3348

17. INFORMANT: Hospital Record.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause	(a) Acute cardiac failure due to	at once
94a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary occlusion from arteriosclerosis	4 days
	(c) Myocardical infarct in left ventricle	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H.V.Deming M.D. H.V. Deming M.D. Cumberland Md. April 28-1950

23. BURIAL, CREMATION REMOVAL (Specify) Buried

DATE THEREOF 5-1-1950

NAME OF CEMETERY OR CREMATORY Hillcrest Cem.

LOCATION (City, town, or county) (State) Cumberland, Md

DATE REC'D BY LOCAL REG. April 30, 1950

REGISTRAR'S SIGNATURE Winter K. Lantz, M.D.

24. FUNERAL DIRECTOR Charles L. George - Cumberland, Md.

ADDRESS

41847

RECEIVED
MAY 5 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03663

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 227 Henderson Ave

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 227 Henderson Ave

3. NAME OF DECEASED (Type or Print) (First) Vernona (Middle) Susannah (Last) Paupe

4. DATE OF DEATH (Month) Apr (Day) 11 (Year) 1950

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH Mar 16, 1896
9. AGE last birthday 54 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk
10b. KIND OF BUSINESS OR INDUSTRY Jewelry Store
11. BIRTHPLACE (State or foreign country) Cumberland, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Henry Paupe
14. MOTHER'S MAIDEN NAME Sophia Ritter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY No. 214-05-5731
17. INFORMANT AND ADDRESS Russell Paupe, Cumberland Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
175x	Immediate cause	(a) Carcinoma of Ovary, left with	Approx 2 yrs
	Antecedent cause(s)	generalized Carcinomatosis	
49a	Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) ~~Intestinal~~ Obstruction secondary to (a)	14 weeks
		(c)	

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION Oct 3 1949
19b. MAJOR FINDINGS OF OPERATION Carcinoma left ovary with generalized metastasis
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sep. 11, 1949, to Apr. 11, 1950, that I last saw the deceased alive on April 10, 1950, and that death occurred at 9:00 A m., from the causes and on the date stated above.

SIGNATURE Wyhe M Haw Jr. (Degree or title) M.D. ADDRESS 6 Washington St. Cumberland Md. DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Apr 14, 1950
NAME OF CEMETERY OR CREMATORY Greenmount Cemetery
LOCATION (City, town, or county) Cumberland (State) Md.

DATE REC'D BY LOCAL REG. April 14, 1950
REGISTRAR'S SIGNATURE Winter R. Frantz M.D.
24. FUNERAL DIRECTOR John J. Hafer ADDRESS Cumberland Md.

26676

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 17 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03664

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland | LENGTH OF STAY (in this place) 2 yrs 3 mos
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sylvan Retreat

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing, Maryland
STREET ADDRESS (If rural, give location) East main St

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Mary	A.	Peebles	4	8	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
F	W	W	Feb 2 1874	76 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Unknown Cyrus Weiland	Unknown Bonnie Gray

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No	None	Melvin Peebles, Lonaconing

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a)	Coronary Occlusion	3½ hrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)	Coronary Sclerosis	10 yrs
(c)		

420.1
94a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At wnrk ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Dec, 1946, to Apr. 8, 1950, that I last saw the deceased alive on Apr. 4, 1950, and that death occurred at 7:20 a.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Arthur F. Jones	M.D.	110 S. Centre St.	Apr. 8, 1950

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	April 10, 50	Oak Hill Cemetery	Lonaconing md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
April 9, 1950	Walter K. Mantz, M.D.	M. Eichorn, Lonaconing	md

RECEIVED
APR 18 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03665

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ~~Barrelville~~ Frostburg
LENGTH OF STAY (In this place) 2 Days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miner's Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Barrelville — Mt. Savage
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) John (Middle) Walter (Last) Porter
4. DATE OF DEATH (Month) 4 (Day) 13 (Year) 1950
5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH Aug. 6, 1877
9. AGE last birthday 72 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) miner
10b. KIND OF BUSINESS OR INDUSTRY Coal Mines
11. BIRTHPLACE (State or foreign country) Wellersburg Pa.
12. CITIZEN OF WHAT COUNTRY? Usa.
13. FATHER'S NAME Henry Porter
14. MOTHER'S MAIDEN NAME Mary Jane Smith
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 215-10-1256
17. INFORMANT Ross Porter Eckard Md.

13. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Chr Myocarditis — INTERVAL BETWEEN ONSET AND DEATH ? ?

422.2 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

93d (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr 1, 1950, to Apr 13, 1950, that I last saw the deceased alive on Apr 13, 1950, and that death occurred at 1:15 P m. from the causes and on the date stated above.

SIGNATURE W O McLane Md (Degree or title) ADDRESS Frostburg Md DATE SIGNED 4-14-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 4/16/1950
NAME OF CEMETERY OR CREMATORY Cooks Mill
LOCATION (City, town, or county) (State) Hyndman, Pa.
DATE REC'D BY LOCAL REG. 4-15-50
REGISTRAR'S SIGNATURE Mrs. Nancy K. Roe
24. FUNERAL DIRECTOR Harvey H. Zeigler ADDRESS Hyndman, Pa.

454 V2

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 19 1950
BUREAU V. S.

Within corporate limits

Dr Van Ormer

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 036664

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland, LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital	STREET ADDRESS (If rural, give location) Robbins Street

3. NAME OF DECEASED (Type or Print) (First) Catherine (Middle) (Last) Powers

4. DATE OF DEATH (Month) April (Day) 10 (Year) 1950

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH March 17, 1885

9. AGE last birthday 65 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) Lonaconing, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Henry Devlin

14. MOTHER'S MAIDEN NAME Annie Woods

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT John Powers, Lonaconing, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

421.4 Immediate cause (a) Valvular Heart Disease, Chronic, with — ?

Antecedent cause(s) Decompensation, probably rheumatic

61 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c) Diabetes mellitus — ?

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURRED While at Work ☐ Not While At work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1 Mar., 1950, to 10 Apr., 1950, that I last saw the deceased alive on 9 Apr., 1950, and that death occurred at 5 35 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Wolfred Van Ormer ADDRESS Cumberland, Md. DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE April 12, 1950 NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery LOCATION (City, town, or county) (State) Lonaconing, Maryland

DATE REC'D BY LOCAL REG. April 11, 1950 REGISTRAR'S SIGNATURE Winter R. Frantz, M.D. 24. FUNERAL DIRECTOR Ellsworth S. Boal, Westernport, Md. ADDRESS

RECEIVED
APR 18 1950
BUREAU U. S.

Outside of City Limits

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03667

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural, Cumberland, rural
LENGTH OF STAY (in this place): 18 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: LaVale, R.F.D. #1

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural, Cumberland, rural
STREET ADDRESS (If rural, give location): LaVale, R.F.D. #1

3. NAME OF DECEASED (Type or Print): (First) WILLIAM (Middle) LOHR (Last) PRICE

4. DATE OF DEATH: (Month) April (Day) 16, (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: April 17, 1877

9. AGE last birthday: 72 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Furniture store

11. BIRTHPLACE (State or foreign country): Hancock, Maryland

12. CITIZEN OF WHAT COUNTRY? ASK.

13. FATHER'S NAME: Martin A. Price

14. MOTHER'S MAIDEN NAME: Melissa Dyer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: 218-16-2829

17. INFORMANT AND ADDRESS: Mrs. Josephine Price Cumberland, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

151x

Immediate cause (a) cancer of the stomach with — INTERVAL BETWEEN ONSET AND DEATH: 6 months

Antecedent cause(s)

46b

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) biliary obstruction — 4 months

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 2-10-50

19b. MAJOR FINDINGS OF OPERATION: cancer of stomach, metastasis into common duct

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-9-, 1950, to 4-16-, 1950, that I last saw the deceased alive on 4-16-, 1950, and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE: L. Wrings (Degree or title) MD — ADDRESS: 57 Greene St. — DATE SIGNED: 4-18-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: 4/19/1950 — NAME OF CEMETERY OR CREMATORY: Greenway Cemetery — LOCATION (City, town, or county) (State): Berkeley Springs, W.Va.

DATE REC'D BY LOCAL REG.: April 19, 1950 — REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR: Wolliam H. Kight, Cumberland, Md. — ADDRESS

26667

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APR 25 1950
BUREAU V. S.

03668

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place) 1 day
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Midland
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Ida (Middle) Mae (Last) Reed
4. DATE OF DEATH (Month) April (Day) 23 (Year) 1950

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH Oct 19, 1891
9. AGE last birthday 58 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME Thomas John Donald
14. MOTHER'S MAIDEN NAME Mary Jane Beeman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs Peter Colmer

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) acute congestive heart failure	11 hours
422.2 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic myocardial disease Enlargement heart	Years
93d	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1948, to 13 April, 1950 that I last saw the deceased alive on 13 April, 1950, and that death occurred at 1:31 P. m., from the causes and on the date stated above.

SIGNATURE John B. Davis, M.D. (Degree or title) ADDRESS Frostburg, Md. DATE SIGNED 4/25/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF April 26, 1950
NAME OF CEMETERY OR CREMATORY Oak HILL Cemetery
LOCATION (City, town, or county) Lonaconing, (State) Md.

DATE REC'D BY LOCAL REG. 4-25-50
REGISTRAR'S SIGNATURE Mrs Nancy H. Roe
24. FUNERAL DIRECTOR M. EICHHORN ADDRESS Lonaconing, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

BUREAU V. D.
APR 27 1950

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

03669

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md.; COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland; LENGTH OF STAY (In this place): 52 yrs.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 517 Fayette St.	STREET ADDRESS (If rural, give location): 517 Fayette St.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Annie	S.	Reith	April	3	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Female	white	married	Feb. 23-1878	72 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	None	Piedmont W.Va.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John F. Gornall	Mary Beall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no	None	Edward A. Reith

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
420,1 Immediate cause	(a) Coronary occlusion	at once
932 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	?
	(c) Chronic myocarditis	2 yrs.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
H.V. Deming M.D. H.V. Deming M.D.	Cumberland Md.	April 4-1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	4/7/1950	Zion Memorial Cemetery	Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
April 7, 1950	Walter L. Hartz, M.D.	William H. Kight, Cumberland, Md.

RECEIVED
APR 11 1950
BUREAU Y. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Dr M Lane
03670
Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
LENGTH OF STAY (in this place): 1 day
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Eckhart
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) KATHERINE (Middle) (Last) REPHANN

4. DATE OF DEATH: (Month) April (Day) 11, (Year) 1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
female	white	widowed	4-25-1868	81 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housework	Home	Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Edward Lancaster	Louise Clise

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
	none	Mrs. Jos. Cunningham, Eckhart, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Chronic Myocarditis	Several months
443x Antecedent cause(s)		
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension	several years
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 1945, 19..., to April 11, 1950, that I last saw the deceased alive on April 11, 1950, and that death occurred at 6:45 P m, from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Wm C Lane MD		Frostburg Md	4-12-50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	4-14-50	Porters Cemetery	Eckhart, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
4-14-50	Mrs. Nancy N. Roe	J. R. Durst, Frostburg, Md.

RECEIVED
APR 17 1950
BUREAU V. S.

Dr. Hodges

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03671

CERTIFICATE OF DEATH

Reg. Dist. No. 2

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

I

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Flintstone Twiggtown; LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Flintstone Twiggtown, Rural
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.D.# 2, Williams Road	STREET ADDRESS (If rural, give location) R.D.# 2, Williams Road

3. NAME OF DECEASED (Type or Print)	(First) Bessie	(Middle) H.	(Last) Rice	4. DATE OF DEATH	(Month) Apr.	(Day) 24,	(Year) 1950	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 1-14-1879	9. AGE last birthday 71 yrs.	If under 1 year Months.	Days	If under 24 hrs. Hours	Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Twiggtown, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Angel Twigg

14. MOTHER'S MAIDEN NAME Julia Imes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No

16. SOCIAL SECURITY No. None

17. INFORMANT AND ADDRESS Charles Rice R.D.#2 Cumberland, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pulmonary Edema,	
Antecedent cause(s)	(b) Chronic Myocarditis	10 hours
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Hypostatic Pneumonia	years 4 days

422.2

93d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
a		Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour) m.	INJURY OCCURRED While at Work ☐	Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 20 50, to April 24 50, that I last saw the deceased alive on April 24 50, and that death occurred at A m., from the causes and on the date stated above.

SIGNATURE A. Royce Hodges (Degree or Title) ADDRESS Cumberland, Md. DATE SIGNED 4/26/50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	4-27-1950	Mt. Pleasant	Near Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
April 27, 1950	Elmer L. Bender.	Charles L. George	Cumberland, Md.

RECEIVED
MAY 1 1950
BUREAU

03672

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place) 70 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
STREET ADDRESS (If rural, give location) 102 Bowery St.

3. NAME OF DECEASED (Type or Print) (First) George (Middle) Milford (Last) Richardson
4. DATE OF DEATH (Month) Apr. (Day) 11 (Year) 1950
5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH 1/11/77
9. AGE last birthday 73 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Mine Foreman
10b. KIND OF BUSINESS OR INDUSTRY Coal
11. BIRTHPLACE (State or foreign country) Eckhart Mines, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME George Richardson
14. MOTHER'S MAIDEN NAME Rose Ann McDonald
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 213-09-6495
17. INFORMANT AND ADDRESS Rance Richardson - 102 Bowery St. Frostburg Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

151x Immediate cause (a) Carcinoma of Stomach — INTERVAL BETWEEN ONSET AND DEATH 4 mo

46b Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION None
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 14, 1949, to Apr. 11, 1950, that I last saw the deceased alive on Apr. 11, 1950, and that death occurred at 10:15 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Wm McLane MD ADDRESS Frostburg Md DATE SIGNED 4-12-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 4/14/50
NAME OF CEMETERY OR CREMATORY St. Michaels Cemetery
LOCATION (City, town, or county) Frostburg (State) Md.

DATE REC'D BY LOCAL REG. 4-13-50
REGISTRAR'S SIGNATURE Mrs. Nancy H. Roe
24. FUNERAL DIRECTOR Jacob Hafer ADDRESS R.B.

454 V2

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 17 1950
BUREAU V. A.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

03673

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A16A

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place): 36 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Times & News Office 7 South Mechanic St.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 822 Schriver Ave.

3. NAME OF DECEASED (Type or Print): (First) Harry (Middle) Heatherington (Last) Robinson

4. DATE OF DEATH: (Month) April (Day) 29 (Year) 1950

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): married

8. DATE OF BIRTH: Oct. 11-1886

9. AGE last birthday: 63 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mgr. Editor of the Cumberland News.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Lonaconing Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John J. Robinson

14. MOTHER'S MAIDEN NAME: Rebecca Bradley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 214-05-8813

17. INFORMANT: Ethel Robinson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Coronary occlusion	at once
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	?
	(c)	

420.1
940

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.): OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title): H.V. Deming M.D. — ADDRESS: H.V. Deming M.D. Cumberland Md. — DATE SIGNED: April 29-1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: May 2, 1950 — NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery — LOCATION (City, town, or county) (State): Cumberland Md

DATE REC'D BY LOCAL REG.: May 2, 1950 — REGISTRAR'S SIGNATURE: Winter R. Koontz, M.D.

24. FUNERAL DIRECTOR — ADDRESS: John J. Hofer Cumberland Md.

V0414

RECEIVED
MAY 5 1950
BUREAU V. S.

Within corporate limits — Arthur Jones

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03674

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; MARYLAND; LENGTH OF STAY (in this place) 29 yrs.; HOSPITAL OR INSTITUTION OR STREET ADDRESS 415 Fayette St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural, give location) 415 Fayette St.

3. NAME OF DECEASED (Type or Print): (First) Elizabeth (Middle) Edna "Daugherty" (Last) Roe

4. DATE OF DEATH: (Month) April (Day) 1 (Year) 1950

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Nov. 13, 1878

9. AGE last birthday: 71 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Akron, Ohio

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Marshall Daugherty

14. MOTHER'S MAIDEN NAME: Alice Crevling

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No

16. SOCIAL SECURITY No.: None

17. INFORMANT AND ADDRESS: Arthur Roe 39 W. Main Frostburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 **Immediate cause** (a) Myocardial failure — Interval Between Onset and Death: 4 days

Antecedent cause(s)

94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Coronary Sclerosis — 5 yrs

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1948, to Apr. 1, 1950, that I last saw the deceased alive on Mar. 31, 1950, and that death occurred at 4 15 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

Arthur F. Jones M. D. — 110 S. Centre St. — Apr. 3, 1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE: April 4 1950 | NAME OF CEMETERY OR CREMATORY: Warwick Cemetery | LOCATION (City, town, or county) (State): Warwick New York

DATE REC'D BY LOCAL REG.: April 3, 1950 | REGISTRAR'S SIGNATURE: Walter R. Hartz, M.D.

24. FUNERAL DIRECTOR | ADDRESS: John J. Hafer, Cumberland, Md.

RECEIVED
APR 11 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

03675 5

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural) near Cumberland
LENGTH OF STAY (in this place) 25 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS in his garage R.F.D.#5 Cresap Park

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural) Cumberland
STREET ADDRESS (If rural, give location) R.F.D.#5 Cresap Park

3. NAME OF DECEASED (Type or Print) (First) Louis (Middle) (Last) Roemer

4. DATE OF DEATH (Month) April (Day) 18 (Year) 1950

5. SEX Male

6. COLOR OR RACE white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married

8. DATE OF BIRTH April 29-1873

9. AGE last birthday 76 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired mechanic, owner

10b. KIND OF BUSINESS OR INDUSTRY Gas Station of garage

11. BIRTHPLACE (State or foreign country) Baltimore Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Conrod Roemer

14. MOTHER'S MAIDEN NAME Margaret

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT Virginia L.Dick Cresap Park, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary occlusion	about 2 minutes
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	?
	(c) Arteriosclerosis	?

420.1 94a

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE H.V.Deming M.D. (Degree or title) H.V. Deming M.D. ADDRESS Cumberland Md. DATE SIGNED April 18-1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF 4/21/50

NAME OF CEMETERY OR CREMATORY Rose Hill Cem.

LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REG. April 20, 1950

REGISTRAR'S SIGNATURE [signature]

24. FUNERAL DIRECTOR H. Wayne George ADDRESS Cumberland, Md.

33284

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
APR 22 1950
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

03676

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place): 50 min.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural) Cumberland
STREET ADDRESS (If rural, give location): R.F.D.#2 Williams Road

3. NAME OF DECEASED (Type or Print): (First) Manuel (Middle) Bernard (Last) Rubenstein
4. DATE OF DEATH: (Month) April (Day) 17 (Year) 1950

5. SEX: male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married
8. DATE OF BIRTH: April-8-1910
9. AGE last birthday: 40 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carman helper
10b. KIND OF BUSINESS OR INDUSTRY: B&O.R.Ry.
11. BIRTHPLACE (State or foreign country): W.Va.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Hiram Rubenstein
14. MOTHER'S MAIDEN NAME: Dora Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 160-12-2116
17. INFORMANT: wife)& Memorial Hospital record

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Coronary occlusion	at once
420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 94a	(b) Coronary sclerosis	?
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H.V.Deming M.D. H. V. Deming M.D.		Cumberland Md.	April 18-1950

23. BURIAL, CREMATION OR REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	April 21,50	Ulrich Cem.	Moorefield W.Va.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	FUNERAL DIRECTOR	ADDRESS
April 19,1950	Walter R. Frantz, M.D.	Louis Stein Sons	Cumberland Md

26647

RECEIVED
APR 25 1950
BUREAU P. R.

Within corporate limits.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03677

Reg. Dist. No. 4

M

I

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS-A15

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; MARYLAND; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural, give location) 706 Bedford St.

3. NAME OF DECEASED (Type or Print): (First) Coleta (Middle) (Last) Ryland

4. DATE OF DEATH: (Month) April (Day) 3 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Write): Single

8. DATE OF BIRTH: Sept 16 1886

9. AGE last birthday: 63 yrs. If under 1 year: Months / Days / If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Cumberland Md

12. CITIZEN OF WHAT COUNTRY: U S A

13. FATHER'S NAME: James Ryland

14. MOTHER'S MAIDEN NAME: Bridget Dobson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Mary Ryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset and Death: 4 days

Antecedent cause(s)

830 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 31, 1950, to April 3, 1950, that I last saw the deceased alive on April 1, 1950, and that death occurred at 6 A. m., from the causes and on the date stated above.

SIGNATURE J. J. Johnson Jr (Degree or title) M.D. ADDRESS Cumberland Md DATE SIGNED 4-4-50

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE Apr 5 50 NAME OF CEMETERY OR CREMATORY St Patricks Cem LOCATION (City, town, or county) Cumberland (State) Md

DATE REC'D BY LOCAL REG. April 5, 1950 REGISTRAR'S SIGNATURE Wynter K. Krantz, M.D.

24. FUNERAL DIRECTOR Louis Stein ADDRESS Cumberland

RECEIVED
APR 11 1950
BUREAU V. S.

Within corporate limits DR. MURRAY

Hafer Frostburg

03678

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND — LENGTH OF STAY (in this place) 1 DAY	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN MT. SAVAGE
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL	STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) BABY GIRL (Middle) (Last) SANDERSON			4. DATE OF DEATH (Month) APRIL (Day) 19 (Year) 1950		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE	8. DATE OF BIRTH APRIL 19-50	9. AGE last birthday ~~1 DAY~~ yrs.	If under 1 year Months. Days 1 / If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Cumberland, Md	12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME VERDETTE SANDERSON			14. MOTHER'S MAIDEN NAME VIRGINIA WINEBRENNER		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)		16. SOCIAL SECURITY No. None	17. INFORMANT AND ADDRESS MEMORIAL HOSPITAL		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Heart & Respiratory Failure

773.5 Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Premature Infant

159 (c) 7 1/2 months gestation

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 18, 1950, to April 19, 1950, that I last saw the deceased alive on April 19, 1950, and that death occurred at 7:10 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

F. Alan G. Murray MD Cumberland Md April 20 50

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE April 21, 1950	NAME OF CEMETERY OR CREMATORY Methodist Cemetery	LOCATION (City, town, or county) (State) Mt. Savage, Md.
DATE REC'D BY LOCAL REG. April 21, 1950	REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.	24. FUNERAL DIRECTOR Jacob Hafer, Frostburg, Maryland	ADDRESS

2-0-4-18-0-25-3-30-3

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 25 1950

Outside of City limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03679

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mar Cumberland Rural; LENGTH OF STAY (in this place) 5 6 years; HOSPITAL OR INSTITUTION OR STREET ADDRESS R.D. #6. Bowling Green

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Allegany COUNTY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mar Cumberland, Rural; STREET ADDRESS (If rural, give location) Rfd 6 Bowling Green

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	George	Laurence	SHAFFER	April	28	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Married	Feb 4, 1885	65 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Machinist	B & O. ~~Duty~~ Railway	Mt. Savage, Md	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Francis F. Shaffer	Margaret Rahrig

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No.	705-05-4605	Chas D. Shaffer - Brother

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

153x **Immediate cause** (a) Carcinoma of Sigmoid — Interval between onset and death: 1 year

462 **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from April 15, 1950, to April 28, 1950, that I last saw the deceased alive on April 27, 1950, and that death occurred at 2:40 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Ralph W. Ballin	M.D.	62 Greene St. Cumberland Md	4-28-50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	May 1, 1950	ST. Patricks	Cumberland,	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
April 30, 1950	Winter L. Lantz, M.D.	Charles L. George	Cumberland, Md.

32647

VS. A15

RECEIVED
MAY 5 1950
BUREAU U. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03680

Reg. Dist. No. 4

1. PLACE OF DEATH · COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS 304 North Centre St.	STREET ADDRESS (If rural, give location) 304 North Centre St.

3. NAME OF DECEASED (Type or Print)	(First) Mattie	(Middle) Frances	(Last) SHANER	4. DATE OF DEATH	(Month) April	(Day) 8	(Year) 1950
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Dec. 27, 1864	9. AGE last birthday 85 yrs.	If under 1 year Months. Days	If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Bedford, Va.	12. CITIZEN OF WHAT COUNTRY? U.S.				
13. FATHER'S NAME Terry Holdren	14. MOTHER'S MAIDEN NAME Martha Huddleston						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)	16. SOCIAL SECURITY No. None	17. INFORMANT AND ADDRESS Alex Shaner Cumberland, Md.					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Senility & Bed sores Infected — 6 weeks

962.0 Antecedent cause(s)

186a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Fracture Left Femur

(c) Second years ago Non union

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Bedridden several years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT ~~SUICIDE~~ ~~HOMICIDE~~ yes (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home	(CITY OR TOWN) Cumberland	(COUNTY) Alley	(STATE) Md
TIME OF INJURY (Month) (Day) (Year) (Hour) 7 years ago m.	INJURY OCCURRED While at Work ☒ Not While At work ☐	HOW DID INJURY OCCUR? Fell in house broken L. Hip		

22. I hereby certify that I attended the deceased from ....., 1943, to April 8, 1950, that I last saw the deceased alive on April 7, 1950, and that death occurred at 4 A.M. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) F. Alan G. Murray MD — ADDRESS Cumberland Md — DATE SIGNED April 8 50

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 4-10-1950	NAME OF CEMETERY OR CREMATORY Holdren Cem.	LOCATION (City, town, or county) (State) Bedford Co. Virginia
DATE REC'D BY LOCAL REG. April 9, 1950	REGISTRAR'S SIGNATURE Wrote R. Frantz, M.D.	24. FUNERAL DIRECTOR Charles L. George	ADDRESS Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 18 1950
BUREAU U. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03681

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland | LENGTH OF STAY (in this place) 17 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Flintstone,
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
AUSTIN	LEO	SHIRCLIFF	April 12, 1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Single	Oct. 17, 1880	69 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sawmill operator	Lumber	Orleans, Md.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Honorious Shircliff	Mary Ann Murray

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
Yes	WW 1	None	Leota Shircliff, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Embolus	36 hours
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Myocardial Infarction	3 weeks
	(c) Coronary Insufficiency due to	6 mos

420.0 93d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Hypertensive & Arteriosclerotic Heart Disease — 10 yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from ....., 19 47, to April 12, 19 50, that I last saw the deceased alive on April 11, 19 50, and that death occurred at 435 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Arnold G. Wiseman MD	122 Bedford St Cumberland	4/12/50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	4/15/1950	St. Patricks Cemetery	Little Orleans, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
April 13, 1950	Wesley K. Hantz, M.D.	William H. Kight	Cumberland, Md.

49609

RECEIVED
APR 18 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 03639 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 50 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 104 South St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland. COUNTY Allegany.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland.
STREET ADDRESS (If rural, give location) 104 South St.

3. NAME OF DECEASED (Type or Print) (First) Asa (Middle) (Last) Irons

4. DATE OF DEATH (Month) Apr. (Day) 20 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH May 20, 1872
9. AGE last birthday 77 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer, Retired
10b. KIND OF BUSINESS OR INDUSTRY Railway
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Irons
14. MOTHER'S MAIDEN NAME Phoebe —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If year, give war or dates of service)
16. SOCIAL SECURITY No.
17. INFORMANT AND ADDRESS Miss Thelma Irons, Cumberland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Chronic Myocarditis	5 yrs.
Antecedent cause(s)	(b) Arteriosclerosis	10 yrs
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Diabetes Mellitus	10 yrs

260x

61

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 1, 1950, to April 20, 1950, that I last saw the deceased alive on April 15, 1950, and that death occurred at 7 30/a m., from the causes and on the date stated above.

SIGNATURE H. U. Eliason (Degree or title) Md. ADDRESS 126 Fremont St. Cumberland Md. DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Apr 23 50
NAME OF CEMETERY OR CREMATORY Rose Hill Cem.
LOCATION (City, town, or county) Cumberland (State) Md.

DATE REC'D BY LOCAL REG. April 22, 1950
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR Louis Stein Inc. ADDRESS Cumberland Md.

98847

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 25 1950
BUREAU V. S.

Within corporate limits.

DR. ROBINSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03682

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE PAW PAW W. VA. COUNTY MORGAN
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) 21 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN PAW PAW
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL	STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	(First) SONDRA	(Middle)	(Last) SHUMAKER	4. DATE OF DEATH	(Month) APRIL (Day) 30 (Year) 1950
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE	8. DATE OF BIRTH FEB 26, 1949	9. AGE last birthday 1 yrs.	If under 1 year Months / Days; If under 24 hrs. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) W. VA.	12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME EDWARD SHUMAKER			14. MOTHER'S MAIDEN NAME WILDA ABE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)	16. SOCIAL SECURITY NO. None		17. INFORMANT AND ADDRESS MEMORIAL HOSPITAL, Cumberland, Md		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

002x Immediate cause (a) Pulmonary Hemorrhage

Antecedent cause(s)

13b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Tuberculosis

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 7, 1950, to April 30, 1950, that I last saw the deceased alive on April 26, 1950, and that death occurred at 5:45 AM, from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Thomas Robinson	M.D.	19 S. Liberty St. Cumberland, Md	5/1/50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	5/2/50	Sulphur Springs Md	Near Keefer	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
May 2, 1950	Winter R. Trant M.D.	W. D. Parks, Berkeley Springs W.Va.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS. A15

RECEIVED
MAY 5 1950
BUREAU U. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03683

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS/A15

1. PLACE OF DEATH: COUNTY ALLEGANY, MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ~~CUMBERLAND, MD.~~ | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL CUMBERLAND, MD.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN FLINTSTONE, MARYLAND
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) RALPH (Middle) (Last) SINGLETON

4. DATE OF DEATH: (Month) APRIL (Day) 23 (Year) 1950

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE

8. DATE OF BIRTH: Nov. 15, 1938

9. AGE last birthday: 11 yrs. | If under 1 year: Months. Days | If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10b. KIND OF BUSINESS OR INDUSTRY: School

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: CALVIN SINGLETON

14. MOTHER'S MAIDEN NAME: GENEVIEVE TEETER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No | (If year, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Chronic Myelogenous Leukemia

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

INTERVAL BETWEEN ONSET AND DEATH: 4 yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

204.1

74a

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1947, to April, 1950 that I last saw the deceased alive on APR. 23, 1950 and that death occurred at 11:35 Pm., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

B. Sutarelic M.D. | R2 Cumberland Md. | 4/23/50

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE 4-26-50 | NAME OF CEMETERY OR CREMATORY Glendale Cem | LOCATION (City, town, or county) (State) Flintstone, Md.

DATE REC'D BY LOCAL REG. April 25, 1950 | REGISTRAR'S SIGNATURE Winter K. Frantz, M.D. | 24. FUNERAL DIRECTOR Charles L. George | ADDRESS Cumberland, Md

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MAY 2
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Dr Wolferman
03684

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; LENGTH OF STAY (in this place) 1 day; HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg, Maryland; STREET ADDRESS (If rural, give location) 26 Washington St.

3. NAME OF DECEASED (Type or Print): (First) James; (Middle) W.; (Last) Stewart

4. DATE OF DEATH: (Month) 4 - (Day) 24 - (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Oct. 14-1861

9. AGE last birthday: 88 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Coal Miner

10b. KIND OF BUSINESS OR INDUSTRY: Coal Mining

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Stewart

14. MOTHER'S MAIDEN NAME: Mary Watson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT AND ADDRESS: John Stewart, Frostburg, Md. (Son)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) pulmonary edema

450.0 Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis, Heart failure

97 (c) Terminal pneumonia

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-23, 1950, to 4-24, 1950, that I last saw the deceased alive on 4-25, 1950, and that death occurred at 3:30 p.m., from the causes and on the date stated above.

SIGNATURE A. Wolferman (Degree or title) M.D. ADDRESS Frostburg DATE SIGNED 4-25-50

23. BURIAL, CREMATION, REMOVAL (Specify) Burial; DATE 4-26-50; NAME OF CEMETERY OR CREMATORY Frostburg Mem. Park; LOCATION (City, town, or county) (State) Frostburg, Md.

DATE REC'D BY LOCAL REG. 4-25-50; REGISTRAR'S SIGNATURE Mrs. Nancy N. Roe

24. FUNERAL DIRECTOR ADDRESS Joseph R. Durst, Frostburg, Md.

45402

RECEIVED
APR 27 1950
BUREAU V. B.

Within corporate limits: Yes

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03685

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY in this place: 3 da.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Garrett
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Oakland Rural
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) Harold (Middle) F. (Last) Stockslager

4. DATE OF DEATH: (Month) April (Day) 7 (Year) 1950

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 8/11/1924

9. AGE last birthday: 25 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Radio Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Radio

11. BIRTHPLACE (State or foreign country): Penna.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Harold F. Stockslager

14. MOTHER'S MAIDEN NAME: Elizabeth Yoder

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No

(If year, give war or dates of service):

16. SOCIAL SECURITY No.:

17. INFORMANT: Harold F. Stockslager Sr.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Malignant Lymphoma, type undet. — Interval between onset and death: 3 years

200.2

Antecedent cause(s)

552

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7 a.m., 19 50, to 7 a.m., 19 50, that I last saw the deceased alive on 7 a.m., 19 50, and that death occurred at 9:15 P m., from the causes and on the date stated above.

SIGNATURE: W. Alfred Van Orma (Degree or title):

ADDRESS: Cumberland, Md.

DATE SIGNED: 8 Apr. 50

23. BURIAL, CREMATION, REMOVAL (Specify): Cremation

DATE: 4/10/50

NAME OF CEMETERY OR CREMATORY: Homewood Crematory

LOCATION (City, town, or county): Pittsburgh

(State): Pa.

DATE REC'D BY LOCAL REG.: April 8, 1950

REGISTRAR'S SIGNATURE: Vernes K. Hartz, M.D.

24. FUNERAL DIRECTOR: Herbert C. Leighton

ADDRESS: Oakland V1857 Md.

BUREAU V. S.
APR 11 1960

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03686

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) 70 years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital	STREET ADDRESS (If rural, give location) 24 Marion Street

3. NAME OF DECEASED (Type or Print)	(First) ROBERT	(Middle) CHRISTIAN	(Last) STOTLER	4. DATE OF DEATH	(Month) April (Day) 11, (Year) 1950 19
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Nov. 28, 1869	9. AGE last birthday 80 yrs.	If under 1 year Months. Days; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) electric welder	10b. KIND OF BUSINESS OR INDUSTRY Railroad B&O	11. BIRTHPLACE (State or foreign country) Mt. Savage, Md.	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Levi H. Stotler		14. MOTHER'S MAIDEN NAME Hannah Bowers			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)	16. SOCIAL SECURITY No. None	17. INFORMANT AND ADDRESS Sarah Stotler, Cumberland, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
450.0 Immediate cause	(a) Congestive heart failure	4 weeks
Antecedent cause(s)		
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) hypostatic pneumonia	2 days
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	generalized arteriosclerosis	2 years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-9, 1950, to 4-11-, 1950, that I last saw the deceased alive on 4-10-, 1950, and that death occurred at 8 40 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
L Wrings	MD	57 Greene St.	4-11-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 4/13/1950	NAME OF CEMETERY OR CREMATORY Greenmount Cemetery	LOCATION (City, town, or county) (State) Cumberland, Md.
DATE REC'D BY LOCAL REG. April 13, 1950	REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.	24. FUNERAL DIRECTOR William H. Kight, Cumberland, Md.	ADDRESS

46447

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 18 1950
BUREAU V. S.

Within corporate limits.

03687

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH — COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) life
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS 824 N. Mechanic St. (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Rose (Middle) C. (Last) Thuss
4. DATE OF DEATH (Month) 4 (Day) 1 (Year) 1950
5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Divorced
8. DATE OF BIRTH 1/5/1894
9. AGE last birthday 56 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Presser
10b. KIND OF BUSINESS OR INDUSTRY Footers Dye Works
11. BIRTHPLACE (State or foreign country) Cumberland, Maryland
12. CITIZEN OF WHAT COUNTRY USA
13. FATHER'S NAME August Thuss
14. MOTHER'S MAIDEN NAME Christine Phillips
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY No. 214-05-6995
17. INFORMANT AND ADDRESS Chas. F. Thuss, Cumberland, Md (brother)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

492 X Immediate cause (a) Virus Pneumonitis — 1 wk

Antecedent cause(s)

109 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Parkinsons Disease — 6 yrs.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar, 1949, to Apr. 1, 1950, that I last saw the deceased alive on Mar. 31, 1950, and that death occurred at 2:45 p m., from the causes and on the date stated above.

SIGNATURE Arthur F. Jones (Degree or title) M.D. — ADDRESS 110 S. Centre St. — DATE SIGNED Apr. 3, 1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial — DATE April 3 1950 — NAME OF CEMETERY OR CREMATORY St. Fuker Cem. — LOCATION (City, town, or county) Cumberland (State) Md.

DATE REC'D BY LOCAL REG. April 3, 1950 — REGISTRAR'S SIGNATURE Winter R. Wantz M.D. — 24. FUNERAL DIRECTOR Louis Stein Inc. — ADDRESS 117 Frederick St.

49601

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

RECEIVED
APR 11 1950
BUREAU V. S.

03688

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (In this place) 1 day
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing
STREET ADDRESS (If rural give location) -

3. NAME OF DECEASED (Type or Print) (First) Edward (Middle) - (Last) Truly
4. DATE OF DEATH (Month) April (Day) 18 (Year) 1950
5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH Sept 25, 1873
9. AGE last birthday 76 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian
10b. KIND OF BUSINESS OR INDUSTRY High School
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME William Truly
14. MOTHER'S MAIDEN NAME Margaret Grahm
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY No. ✓
17. INFORMANT Lavern Condon

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Hypertensive arteriosclerotic cardio-

442X

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) vascular-renal disease with auricular

131a

(c) arrhythmia and uremia. 6 mo.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1949, to 4/18, 1950, that I last saw the deceased alive on 4/18, 1950, and that death occurred at 1745 A.m., from the causes and on the date stated above.

SIGNATURE Paul Eugene Frye (Degree or title) M.D ADDRESS Lonaconing Md DATE SIGNED 4/20/50

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL
DATE THEREOF APRIL 21, 1950
NAME OF CEMETERY OR CREMATORY Oak HILL Cemetery
LOCATION (City, town, or county) Lonaconing, (State) Md.
DATE REC'D BY LOCAL REG. 4-20-50
REGISTRAR'S SIGNATURE Mrs. Nancy N. Roe
24. FUNERAL DIRECTOR M. Eichhorn ADDRESS Lonaconing, Md.

60291

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 22 1950
BUREAU V. S.

Within corporate limits

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03689

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 436 Columbia St.

3. NAME OF DECEASED (Type or Print): (First) Caroline (Middle) Wilhelmina (Last) Walsh

4. DATE OF DEATH: (Month) 4 (Day) 15 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Aug. 23, 1872

9. AGE last birthday: 77 yrs. — If under 1 year: Months, Days — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: Adam Zink

14. MOTHER'S MAIDEN NAME: Magdelene Meiers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service):

16. SOCIAL SECURITY No.: None

17. INFORMANT AND ADDRESS: Daughter Lena Walsh, 436 Columbia Ave.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

704.1 Immediate cause (a) Pemphigus — 4 yrs

Antecedent cause(s)

153 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 9, 1949, to Apr. 15, 1950, that I last saw the deceased alive on Apr. 12, 1950, and that death occurred at 7:46 a m., from the causes and on the date stated above.

SIGNATURE: Arthur F. Jones M.D. (Degree or title) — ADDRESS: 110 S. Centre St. — DATE SIGNED: Apr. 16, 1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: 4/17/50 — NAME OF CEMETERY OR CREMATORY: St. Luke's Cemetery — LOCATION (City, town, or county): Cumberland, Allegany (State): Md.

DATE REC'D BY LOCAL REG.: April 17, 1950 — REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR: Louis Stein, Inc. — ADDRESS: Cumberland, Md.

RECEIVED
APR 25 1950
BUREAU V. S.

Within corporate limits D. Baillin

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03690

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland | LENGTH OF STAY (in this place) life Time
HOSPITAL OR INSTITUTION OR STREET ADDRESS 111 S. Lee Street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 111 S. Lee St.

3. NAME OF DECEASED (Type or Print): (First) Alexander (Middle) Hamilton (Last) Washington
4. DATE OF DEATH: (Month) April (Day) 27 (Year) 1950
5. SEX: Male
6. COLOR OR RACE: Black
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Aug 17, 1867
9. AGE last birthday: 82 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Car Washer-
11. BIRTHPLACE (State or foreign country): Cumberland, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Thomas Washington
14. MOTHER'S MAIDEN NAME: Fanny ?
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No
16. SOCIAL SECURITY No.: None
17. INFORMANT AND ADDRESS: Mrs Alma Mason - 97 Chestnut St. Keyser, W.Va.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

481x **Immediate cause** (a) Influenza — Interval between onset and death: 10 days

Antecedent cause(s)

33b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-17, 1950, to 4-27, 1950, that I last saw the deceased alive on 4-26, 1950, and that death occurred at 7:50 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Ralph L. Baillin, M.D. 62 Greene St. Cumberland, Md 4-28-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE: May 1, 1950 | NAME OF CEMETERY OR CREMATORY: Woodlawn Burial Park | LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: April 29, 1950 | REGISTRAR'S SIGNATURE: Walter L. Hartz, M.D. | 24. FUNERAL DIRECTOR ADDRESS: John J. Hafer, Cumberland, Md.

90299

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
MAY 2 1950
FCC
BUREAU

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STANDARD CERTIFICATE OF DEATH

FORM APPROVED
Budget Bureau No. 41-R132-42

State File No. _____
Registrar's No. 03691
District No 6

State of Maryland

1. PLACE OF DEATH:
(a) County Allegheny
(b) City or town McCoole (If outside city or town limits, write RURAL)
(c) Name of hospital or institution: Queen Street (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ In this community eight months. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County _____
(c) City or town McCoole (If outside city or town limits, write RURAL)
(d) Street No. Queen Street (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) FULL NAME Benjamin Franklin Wilkins
3. (b) If veteran, name war None
3. (c) Social Security No. None
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Rachel Wilkins
6. (c) Age of husband or wife if alive 77 years
7. Birth date of deceased Dec. (Month) 31 (Day) 1872 (Year)

8. AGE: Years	Months	Days	If less than one day
77	3	19	hr. _____ min.

9. Birthplace Lost River, Hardy Co. W.Va (City, town, or county) (State or foreign country)
10. Usual occupation Farmer
11. Industry or business Farm tenant

MOTHER FATHER
12. Name Abraham Wilkins
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name Rachel Wilkins
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Elsie Robison
(b) Address McCOOle, Maryland
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 23'50 (Month) (Day) (Year)
(c) Place; burial or cremation Asbury Cemetery Pendelton County, W. Va.
18. (a) Signature of funeral director Merrill E. Coulter
(b) Address Romney, W. Va.
19. (a) Apr 23 50 (Date received local registrar) (b) _____ (Registrar's signature)

MEDICAL CERTIFICATION

20. Date of death: Month April day 20th. year 1950 hour 11 A. M. minute _____
21. I hereby certify that I attended the deceased from March 28, 1950, to April 20, 1950, that I last saw him alive on April 20, 1950; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Bronchial pneumonia	5 days
Due to Confluenza	6 days
Due to _____	
Other conditions Congestive Heart Failure (Include pregnancy within 3 months of death)	

PHYSICIAN

Major findings:
Of operations 33a
Of autopsy _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____ (Specify type of place)
While at work? _____ (e) Means of injury _____
23. Signature Wm. F. McFarland (M. D. or other) MD
Address Keyser W.Va Date signed 4-22-50

8-6917a

U. S. GOVERNMENT PRINTING OFFICE 16—13403-1

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APR 26 1950
BUREAU V. S.